MEDICAL INFORMATION FORM
PARENT/GUARDIAN SECTION (Please print)

CAMPER'SNAME_____CAMPSESSION_____DATES_____
Last First I

Parent/Guardian _____Address_____

City_____ State_____ Zip_____Phone (____)_____ Emergency Phone (_____)_____

M___ F___ Birth Date _____ Physician _____ Phone (_____)_____

PARTICIPANT'S HEALTH HISTORY: Please check:

ASTHMA*	☐ Yes	☐ No	ADD/ADHD	☐ Yes	☐ No	Headaches	☐ Yes	☐ No
HEART DEFECT/DISEASE*	☐ Yes	☐ No	Head Lice (recent)	☐ Yes	☐ No	Fainting	☐ Yes	☐ No
SEIZURES*	☐ Yes	☐ No	Bed wetting	☐ Yes	☐ No	Ear Infections	☐ Yes	☐ No
DIABETES*	☐ Yes	☐ No	Sleepwalking	☐ Yes	☐ No	**UNDER DR.'S CARE***	☐ Yes	☐ No
RECENT HOSPITALIZATION*	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	Other(explain below)	☐ Yes	☐ No

* Note: If "Yes" for any **BOLD*** items above, a Doctor's written authorization is required prior to attending camp. (Form on back of this page.)

Childhood Diseases:_____

Date of last Tetanus injection _____ D**ate of last Physical Exam** _____

List all reactions to any medications . _____

_____)_____

Food allergies or other allergies? _____

List any recent operations or injuries which would be helpful to camp Medical staff _____

_____

Any recent illness (past two months)? _____

List any medications being sent to camp (**all medications must be in original container.**) _____

_____

Is there any special medical or dietary care needed? _____

Are there any restrictions in any of the physical programs (swimming, hiking, games, etc.?) _____

_____

Use this space to provide any additional information about the participant's behavior and physical, emotional or mental health about which the camp should be aware. _____

_____

_____

Insurance Information

Medical Insurance Carrier_____ Policy and/or Group # _____

Signature of Parent/Guardian completing form;_____Date_____

THE FOLLOWING MUST BE COMPLETED

Unless this form is signed by a parent or guardian, the Camp cannot get emergency help for your child in case of injury. This technical wording is controlled by the dictates of State Law. Thank you for your cooperation.

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

(I) (We), the undersigned, parents of _____, a minor, having legal custody of said minor and having entrusted said minor into the care of the agent(s) hereinafter named, do hereby authorize the staff of Camp Stevens as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is to be rendered under the general or special supervision and upon the advice of any physician and surgeon licensed under the provisions of the Medicine Practice Act or to consent to any x-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care to be rendered to said minor by a dentist licensed under the provisions of the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or at a licensed hospital, or at any other place or places.

It is understood that this authorization is given in advance of any specific examination, diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such examination, diagnosis, treatment or hospital care which the aforementioned physician may advise.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

The undersigned further agree(s) to indemnify and hold harmless the Protestant Episcopal Church in the Dioceses of Los Angeles and San Diego, each and any of its institutions, societies or subdivisions, and each employee or agent of any of them, from any loss, cost (including cost of investigation or defense of claims and legal fees), liability or damage which may be sustained or may rise out of the performance, non-performance or mis-performance of any examination, anesthetic, diagnosis, treatment or hospital care performed as a result of or following any consent or purported consent by said agent(s) hereunder.

This authorization shall remain effective through _____ unless sooner revoked in writing delivered to said agent(s), no revocation shall render said agent(s) liable, nor place said agent(s) under any duty, with respect to any consent given hereunder prior to actual receipt by said agent(s) of such revocation.

Dated:_____ _____
Parent/Guardian

NO ONE WILL BE ADMITTED WITHOUT THIS FORM
Complete Both Sides of this Form

PHYSICIAN'S SECTION

Required if a camper has a history of Asthma, Heart defect/disease, Seizures, Diabetes, has been recently hospitalized or is currently under a doctor's care.

Physician - please note: Because of the camper's medical history, we have asked for your written authorization prior to the campers attendance. The program consists of a variety of active life-style activities, including strenuous hiking, games and activities in the forest and grass meadows in and near the camp, at an elevation of 4,300 feet. Your careful consideration is appreciated.

MEDICATION ALLERGIES_____

FOOD ALLERGIES_____

DATE OF LAST TETANUS BOOSTER_____

REMARKS

_____

CHECK:

Nose _____	**Throat** _____	**Heart** _____
Skin _____	**Hernia** _____	**Abdomen** _____
Ears _____		

Are there any restrictions in any of the physical programs (swimming, hiking, games etc.?)_____

_____

I have examined the applicant for entrance to Camp Stevens and find the camper physically qualified to be accepted as a camper and to enter into all camp activities except as noted.

Signed _____ **Date** _____

Physician's name _____ Phone (_____)_____

Please print

This applicant is approved for Back-packing at altitudes over 10,000 Feet.

Signed _____ **Date** _____

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