

# MEDICAL INFORMATION FORM

## PARENT/GUARDIAN SECTION (Please print)

CAMPER'S NAME \_\_\_\_\_ CAMP SESSION \_\_\_\_\_ DATES \_\_\_\_\_

Last                      First                      Middle Initial

Parent/Guardian \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Emergency Phone (\_\_\_\_) \_\_\_\_\_

M \_\_\_ F \_\_\_ Birth Date \_\_\_\_\_ Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**PARTICIPANT'S HEALTH HISTORY:** Please check:

- |   |  |  |
|---|--|--|
| <b>ASTHMA*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                 | <b>ADD/ADHD</b> <input type="checkbox"/> Yes <input type="checkbox"/> No           | <b>Headaches</b> <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| <b>HEART DEFECT/DISEASE*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No   | <b>Head Lice (recent)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Fainting</b> <input type="checkbox"/> Yes <input type="checkbox"/> No             |
| <b>SEIZURES*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No               | <b>Bed wetting</b> <input type="checkbox"/> Yes <input type="checkbox"/> No        | <b>Ear Infections</b> <input type="checkbox"/> Yes <input type="checkbox"/> No       |
| <b>DIABETES*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No               | <b>Sleepwalking</b> <input type="checkbox"/> Yes <input type="checkbox"/> No       | <b>UNDER DR.'S CARE*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| <b>RECENT HOSPITALIZATION*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Tuberculosis</b> <input type="checkbox"/> Yes <input type="checkbox"/> No       | <b>Other(explain below)</b> <input type="checkbox"/> Yes <input type="checkbox"/> 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** \_\_\_\_\_ **Date 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 # \_\_\_\_\_

**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.

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.

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 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 Signature

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

