

CAMPER
HEALTH FORM 2010

To be completed by parent.



21 Camp Greystone Ln., Zirconia, NC 28790
Phone: (828) 693-3182 Fax (828) 693-1562

**Please complete and return
to camp by your deadline on
front of booklet.**

CAMPER FULLNAME: _____ **NAME CAMPER GOES BY:** _____

Session: Junior June Main August

Social Security # _____ Birthday _____ Age _____ **Last Year & Session Attended?** _____

Address _____

Home Phone (____) _____ Mom Cell (____) _____ Dad Cell (____) _____ Work(____) _____

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child as named above. (Camp Greystone will always make every effort to consult with parents concerning serious health situations.) I further give permission to the Camp Greystone nursing and medical staff to administer prescription and nonprescription medication brought from home as well as those prescribed or determined necessary while at camp.

SIGNATURE _____ **Print Parent Name** _____

If I am not available in an emergency, please notify:

1. Name _____ Home Phone (____) _____ Cell (____) _____

Relationship to camper: _____

2. Name _____ Home Phone (____) _____ Cell (____) _____

Relationship to camper: _____

Insurance Company: _____

Name of Policy Holder: _____ D.O.B: _____

YOU MUST ATTACH A COPY OF YOUR INSURANCE CARD (FRONT AND BACK)!

HEALTH HISTORY - Does camper have a history of:

Asthma	Yes No	Behavior or emotional concerns	Yes No	Hepatitis	Yes No
Seizures	Yes No	ADD	Yes No	Any previous surgery	Yes No
Diabetes	Yes No	Eating Disorders	Yes No	Allergic to Penicillin	Yes No
Heart Murmurs	Yes No	Severe reaction to poison ivy	Yes No	Allergic to other drugs	Yes No
Cardiac problems	Yes No	Severe reaction to insect stings	Yes No	Any other allergies	Yes No
Orthopaedic problems	Yes No	Breathing problems	Yes No	Any diet restrictions	Yes No
Frequent ear infections	Yes No	Bringing bee sting kit	Yes No	Frequent headaches	Yes No
Within last 2 years	Yes No	Glasses	Yes No	Lice	Yes No
Has she had Chicken Pox	Yes No	Contacts	Yes No	Skin conditions	Yes No
Has she menstruated	Yes No	GI or stomach problems	Yes No		
Menstrual history normal	Yes No	Kidney or bladder problems	Yes No		

Please list any details related to the above health history or special instructions, including medications or home aerosol machines.

Is camper currently under care of Dr. or Counselor? Yes or No. If yes, please explain: _____

PLEASE BE SURE THAT:

- 1) YOU HAVE ATTACHED A COPY OF YOUR INSURANCE CARD FRONT AND BACK!
(THIS IS REQUIRED BY OTHER FACILITIES SHOULD WE NEED TO USE ONE.)**
- 2) YOU HAVE SIGNED THE SIGNATURE BOX ABOVE.**
- 3) THE ENTIRE FORM IS COMPLETE, INCLUDING IMMUNIZATIONS ON REVERSE!**

