All medication must be in original bottles

NOTE: This information will only be shared on a need to know basis, and only with those responsible for camp & special activities.

Hampshire County Sheriff's Department Kids Kamp

HEALTH AND MEDICAL RECORD

Camper's Name _____ Date of Birth _____

In Case of Emergency, Notify:

Name_____ Relationship _____

Address_____ _____

Home Phone _____Daytime Phone _____

In the event the above person cannot be reached, give backup contact:

Name_____ Relationship _____Phone _____

HEALTH HISTORY *(to be completed by parent/guardian)*

Any allergies (food, bee stings, etc.) or reaction to any medication? No _____ Yes_____

List:_____

Any condition now requiring regular medical treatment or ongoing medication? No_____ Yes_____

List:_____

List medications camper will need to take during camp.

Medication:_____ Dosage: _____Frequency: _____

Medication:_____ Dosage: _____Frequency: _____

Any restriction of activity for medical reasons) No_____ Yes_____

Explain:_____

Is this person currently or have they recently undergone counseling or therapy? No_____ Yes_____

State reason for treatment: _____

Counselor's Name & Phone Number: _____

Has this person had more than a brief minor illness or injury during the past year? No_____ Yes_____

List & explain:_____

State history of any serious illness / Injury/hospitalization:

Has there been any major change in the family's situation in the last year? No_____ Yes_____

Explanation: _____

HAS THIS PERSON HAD: *(please place mark in appropriate column)*

	Now	Past	Never		Now	Past	Never
Asthma/Sinus Trouble	____	___	____	Bed Wetting	___	___	___
Earache/Ear Infection	____	___	____	Sleep Walking	___	___	___
Severe Stomachaches	____	___	____	Seizures	___	___	___
Fainting Spells	____	___	____	Frequent Diarrhea	___	___	___
Menstrual Problems	____	___	____	High/Low Blood Pressure	___	___	___

Is there anything else you would like the camp to be aware of?

List:_____

PARENT'S AUTHORIZATION

(Required for those under 18 years of age)

To the best of my knowledge this health history is correct. Except as noted on this form my child as named above has my permission to engage in all prescribed activities**. 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 and/or anesthesia and/or surgery for my child as named above.**

Can we give your child over-the-counter medication? Yes_____ No_____

Signature (Parent/Guardian)

MEDICAL INSURANCE INFORMATION

Do you have medical insurance coverage? Yes_____ No_____ If so, please supply the following information:

Name & Address of Insurance Company _____

Name & Address of Insured Person _____