CAMP LOOKOUT
HEALTH INFORMATION FORM

Name:______________________ Birthdate:__________ Age:______

Parent/Guardian:______________________ Phone # Home:______________

Cell:______________

Work:______________

Address:____
Street City State Zip Code

If parent or guardian is not available in an emergency notify: (name 2 please)

1. Name:______________ Relationship:__________ Phone #:______________
2. Name:______________ Relationship:__________ Phone #:______________

HEALTH HISTORY

(*give approximate dates*)

Please indicate if your child is allergic to any of the following:

Medication Allergies:______________ Symptoms/Treatment:______________

Environmental Allergies:______________ Symptoms/Treatment:______________

Insect/Bee/Wasp Stings:______________ Symptoms/Treatment:______________

Specific Foods:______________ Symptoms/Treatment:______________

Immunizations:______________ Specific Tetanus: (*Last date received*)______________

Does your child have any of the following recurrent or chronic illnesses or problems:

Ear infections:______________ Date of occurrence/Treatment:______________
Diabetes:______________ Date of occurrence/Treatment:______________
Poison Ivy/Oak, etc:______________ Date of occurrence/Treatment:______________
Asthma:______________ Date of occurrence/Treatment:______________
Menstrual Problems:______________ Date of occurrence/Treatment:______________
Sleepwalking:______________ Date of occurrence/Treatment:______________
Lice Infestation:______________ Date of occurrence/Treatment:______________
Misc.:______________ Date of occurrence/Treatment:______________

- Does your child need to be awakened in the middle of the night to avoid having an accident? Yes No
- Do you know of any health factors that make it advisable for your child to follow a limited program of physical activity? Yes No

  Please explain:____
- Please specify any information that might be helpful to the staff in caring for your child:______________

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PLEASE COMPLETE BOTH PAGES OF THIS FORM

DAILY MEDICATIONS LIST

If your child is on daily medications, these medications will be kept in the Director's cabin and administered by the Senior Counselor of that cabin.

Please list all the medication names, doses and administration times below. **Please send only the amount your child will need while at camp in appropriate labeled containers.** This should include headache medicine for your child.

Medication Name	Dose	Frequency/Times to be given	Special Instructions

** Please remember to pick up the medications on Friday night. Note: they will be disposed of if not picked up*

PARENT/GUARDIAN'S AUTHORIZATION

This health history is correct and my child has permission to engage in all prescribed camp activities unless otherwise stated above. In the event I cannot be reached in an EMERGENCY, I herby 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 named on this form.

______________________________ ______________

Signature of Parent/Guardian Date

While your child,______________________________, is at Camp Lookout (should minor incidences occur) we would like your permission to administer to your child, on an as needed basis, the following:

Yes No Tylenol (*please specify dose*)______________

Yes No Insect Repellant

Yes No Visine eye drops

Yes No First Aid products- Dactine, Peroxide, Cleanser, Other______________

Yes No Other______________________________

*Please understand this is only on an as needed basis when we assess the problem, and if it is or becomes more serious you will be notified immediately.

Parent/Guardian Signature:______________________________ Date:______________

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