



2011 CAMPER HEALTH FORM

CAMP FREDERICK
6996 Millrock Road
Rogers, OH 44455

PHONE: 330-227-3633 FAX: 330-227-9005

OFFICE USE ONLY

COUNSELOR: _____

CABIN: _____

Camper Name: _____

Birth date: _____ **Gender:** _____ **Age:** _____

Program Name: _____ **Dates/Year** _____

Parent/Guardian: _____

Phone: () _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Work Phone: () _____ **Pager #:** () _____

Email: _____ **Cell Phone:** () _____

Health Insurance: _____ **Group** _____

Parent with Primary Insurance: _____ **ID # or SS#** _____

Please attach a photocopy of your insurance card.

If not available in an emergency, notify:

Name: _____ **Phone:** () _____

Name: _____ **Phone:** () _____

Physician's Name: _____ **Phone:** () _____

HEALTH HISTORY:

To be completed by Parent/Guardian. Circle YES or NO. Provide additional information for YES answers.

Does your child have any allergies? YES NO

Does your child have a history of surgery, injury, hospitalizations, or chronic problems? YES NO

Does your child have any special restrictions or other needs while at camp? YES NO

Does your child receive any treatment for emotional, learning, or psychological needs? YES NO

Does your child have any special food or dietary needs? YES NO

If your child is female, has she started to menstruate? _____ If not, has she been told about it? _____
If yes, does she have any problems during menstruation?

Is your child a vegetarian? YES NO

Has your child ever been to camp before? YES NO

Has your child ever been homesick? YES NO

Does your child wear glasses/contacts? YES NO

Does your child have braces? YES NO

Does your child wear a retainer? YES NO

Has your child had chicken pox? YES NO

Is your child on any prescribed medication that will need to be administered while at camp? YES NO

If yes, please list the medications. Upon arrival at camp, you will need to complete a medication dosage and schedule form.

PLEASE NOTE: ALL MEDICATION MUST BE SENT TO CAMP IN ITS ORIGINAL CONTAINER.

Is there anything else you would like the camp staff to know about your child's health history?

Immunization Record: List the dates your child received the following immunizations.

DPT series: _____

Mumps: _____

Measles: _____

Rubella: _____

Polo Series: _____

Hepatitis B series: _____

Tetanus Booster: _____