

**2023 Winter Camp Health/Medical Form:**

**\*This form will be kept with the First Aid Director\***

Camper Name: \_\_\_\_\_

Birth Gender:

Boy  Girl

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Camper's Primary Residence is with:  Both Parents  Mother  Father  Other \_\_\_\_\_

**Other Emergency Contacts** (For your camper's safety, this person MUST speak English.):

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Relation to Camper: \_\_\_\_\_

Relation to Camper: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

**Parent/Camper Agreement:**

I understand as a parent/guardian I am responsible for my child's medical obligations. In an emergency, I give permission to the physician selected by the camp to hospitalize, secure treatment, & order any other treatment(s) necessary under the Medical Practice Act for my child. I give permission to the health care providers at Victory Ranch to give over-the-counter medication & administer any other treatment to my child as they deem necessary. I have read, understand, & agree to the above.

**Parent/Guardian Signature**

**Date**

**Camper Medical Information:**

Current Medications taken regularly: \_\_\_\_\_

Special Conditions: \_\_\_\_\_

Allergies (please list/check): \_\_\_\_\_

Asthma  Bee Stings  Heart Trouble  Measles  Mumps  Menstrual Cramps  Sleepwalking  Swimming Restrictions

**If your child is currently taking medication, PLEASE send medicine to camp in the original, labeled container.**

Recent exposure to contagious disease: \_\_\_\_\_

Immunizations up to date:  Yes  No Date of last tetanus shot: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

**I authorize the following individuals (family member, church, etc.) to pick up my child from camp:**

**Office Use Only**

**Health Supervisor Statement:**

Screening to identify evidence of illness, injury, or disease has been completed.

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
**Health Supervisor Signature**

\_\_\_\_\_  
**Signature of person picking up child**

\_\_\_\_\_  
**Date**

Valid ID

\_\_\_\_\_  
**Signature of person checking ID**

\_\_\_\_\_  
**Date**