HEALTH FORM

CROSS ROADS CAMP & RETREAT CENTER

Camper Name: _____ Birth Date: ___/___/_____

Program Name: DAY CAMP Age: _____

Camper Address: _____ Sex: ☐ Male ☐ Female

_____

Home Phone: (____)_____

Parent/Guardian: _____ Home Phone: (_____)_____

Address: _____ Work Phone: (_____)_____

Name of Health Insurance*: _____ Group/Policy #: _____

Name of Parent Carrying Health Insurance: _____ Parent SS#: _____

Please include a copy of the front and back of your insurance card

If not available in an emergency, notify:

Name: _____ Phone: (_____)_____

Name: _____ Phone: (_____)_____

Name of Physician: _____ Phone: (_____)_____

HEALTH HISTORY

To be completed by Parent/Guardian

Chronic Problems:

☐ Ear infections
☐ Asthma
☐ Diabetes
☐ Headaches
☐ Bedwetting
☐ Sleepwalking
☐ Learning Disability
☐ Psychiatric Care
☐ Seizures
☐ Other: _____

Describe Management of chronic problems and/or allergies: _____

_____

_____

_____

Describe past medical treatments, surgeries, hospitalization, injuries, special restrictions, or considerations while at camp: _____

_____

_____

Describe treatment your son/daughter receives for emotional, learning, or psychological concerns: _____

_____

_____

Allergies:

☐ Food
☐ Medication
  ☐ Penicillin
  ☐ _____
☐ Insect Stings
☐ Hay Fever
☐ Other: _____

For Female: has this person menstruated? _____ If not, has she been told about it? _____
If so, is her menstrual history normal? _____ Special considerations: _____

_____

Dietary Restrictions: _____

_____

Is your son/daughter a vegetarian?	☐ Yes	☐ No
Has your son/daughter had chicken pox?	☐ Yes	☐ No
Has your son/daughter ever been to camp before?	☐ Yes	☐ No
Has your son/daughter ever been homesick?	☐ Yes	☐ No
Does your son/daughter wear glasses/contacts?	☐ Yes	☐ No
Does your son/daughter have braces?	☐ Yes	☐ No
Does your son/daughter wear a retainer?	☐ Yes	☐ No

Immunization Dates:
(month/year)

___/___ DPT series
___/___ Mumps
___/___ Measles
___/___ Rubella
___/___ Polio Series
___/___ Hepatitis B Series
___/___ Tetanus Booster

Please list any medications and send with directions: _____

_____

_____