

# Medical History Form

*Please submit this form and a photocopy of your insurance card (front & back).  
Don't forget your card – your child may need it!*

Name \_\_\_\_\_ DOB \_\_\_\_\_ Sex \_\_\_ Age \_\_\_ Height \_\_\_ Weight \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Known Drug \_\_\_\_\_

Allergies \_\_\_\_\_ SS# \_\_\_\_\_

## Health History-check any illness the camper has experienced

\_\_\_\_\_ Asthma \_\_\_\_\_ Allergies \_\_\_\_\_ Sinus Infections \_\_\_\_\_ Hospitalization

\_\_\_\_\_ Headaches \_\_\_\_\_ Dizziness/fainting \_\_\_\_\_ Heart trouble \_\_\_\_\_ Seizures

\_\_\_\_\_ Urinary infection \_\_\_\_\_ Diabetes \_\_\_\_\_ Blood condition \_\_\_\_\_ Earaches

\_\_\_\_\_ Surgeries \_\_\_\_\_ Physical handicaps \_\_\_\_\_ Injuries \_\_\_\_\_ Eye condition

\_\_\_\_\_ Breathing difficulties \_\_\_\_\_ Behavioral or psychological conditions

**\*Note: If you use an inhaler, you must bring it to camp with you...no exceptions!**

1. Explain any of the conditions checked above &/or any other condition:

2. Describe medications taken in the last 12 months for the condition checked:

3. Is your child currently taking any medication(s)? NO YES.

If yes, please state name of medication(s) and dosage. (**ALL PRESCRIPTION MEDICATIONS MUST BE IN THE CONTAINER WITH THE PHARMACY LABEL**)

4. What non-prescription medications do you give permission for your child to take while at camp? (**ANY MEDICATIONS SENT WITH YOUR CHILD TO CAMP MUST BE IN A CONTAINER WITH IDENTIFICATION OF MEDICATION AND DOSE TO BE GIVEN**)

\_\_\_\_\_ Pain Relief or Fever Control (Tylenol, Advil, etc.) \_\_\_\_\_ Decongestant (Sudafed, etc.)

\_\_\_\_\_ Antihistamine (Benadryl, etc.) \_\_\_\_\_ Others

5. Does your child have any condition that limits physical activity or sports? NO YES

Describe:

6. Does your child wear any type of medical alert identification? NO YES (If yes, attach a note from the physician for permission to attend this camp and an explanation of what is to be done in an emergency)

7. Date of last Tetanus injection (if unknown, please indicate such)

## IN CASE OF AN EMERGENCY

Parent: \_\_\_\_\_ Home phone (\_\_\_\_) \_\_\_\_\_

Mobile phone: \_\_\_\_\_ Work phone (\_\_\_\_) \_\_\_\_\_

Alternate person \_\_\_\_\_ Contact phone(\_\_\_\_) \_\_\_\_\_

**I HEREBY AUTHORIZE PHYSICIANS, NURSES AND ASSISTANTS OF THE LOCAL HOSPITAL TO PERFORM ALL TREATMENTS AND PROCEDURES AS ORDERED AND DEEMED NECESSARY IN CASE OF AN EMERGENCY UPON:**

Camper(Print) \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_

Relationship to Camper \_\_\_\_\_ Date \_\_\_\_\_

**Mail to: FC Arkansas Camp, c/o Sherri Finley, 2530 NW 30th St., Newcastle, OK 73065**

**-or- fax toll free to: 1-866-702-1657**