Medical History Form

Please submit this form and a photocopy of your insurance card (front & back). Don't forget your card – you 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? (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 Name (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
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