RAWHIDE SM Adventure Camp Health Form

This form must be completed by a parent or guardian and mailed to Rawhide at least two weeks prior to departure.

Last Name: _____ First Name: _____ Middle Initial: _____
Birth Date: _____ Age: _____ Height: _____ Weight: _____
Parent/Guardian: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Dad's Cell: _____ Mom's Cell: _____

Health History:

	YES	NO		YES	NO		YES	NO
Asthma	☐	☐	Epilepsy	☐	☐	Seizures	☐	☐
Diabetes	☐	☐	Hepatitis B	☐	☐	Physical Disabilities	☐	☐
Sleepwalking	☐	☐	Special Diet	☐	☐	Stomachaches	☐	☐
Earaches	☐	☐	Heart Condition	☐	☐			

Allergic to:

	YES	NO		YES	NO
Insect Stings:	☐	☐	Penicillin:	☐	☐

Foods: _____ Other Drugs: _____
Date of last tetanus booster: _____

Emergency Contact Person:
(In case parent/guardian cannot be reached)
Last Name: _____ First Name: _____ Middle Initial: _____
Address: _____
City: _____ State: _____ Zip:
Home Phone: _____ Work Phone: _____
Cell Phone: _____

Your Insurance Information:
Health Insurance Company: _____ Phone: _____
Insurance Company Address: _____
Insurance Policy #: _____ Group #: _____ Expiration Date: _____

List any activity restrictions and/or medication your child is taking:

_____
_____
_____
_____

NOTE: Rawhide and Forest Springs cannot administer prescription medications to campers under the age of 18 without written instructions **AND** written permission of a parent or guardian AND physician. Please indicate name of medication, dosage frequency, time to be given, and other instructions on the Physician's Authorization Form. Medications need to be in the original prescription bottle/container with instructions showing the camper's name and an expiration date.

Emergency Release:
I hereby certify that _____ is in good health, free from and not exposed to communicable diseases within the last three weeks prior to camp time, and is able to participate in all camp activities.

Rawhide staff have my permission to provide prescribed or over-the-counter medication as directed on the Physician's Authorization to Dispense Medications form. IN CASE OF MEDICAL and/or SURGICAL EMERGENCY or other necessary medical attention, I hereby give permission to the trained medical staff selected by the camp director to hospitalize, secure proper treatment for, and order injection, anesthesia, x-rays, or surgery for my child as named above. I agree not to obligate Rawhide or Forest Springs to pay medical bills related to treatment.

Parent/Guardian Signature:_____ Date:_____