

**PART 1: SAC CAMPER HEALTH INFORMATION**

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex  M   F

Parent's/Guardian's Name \_\_\_\_\_ Parent's/Guardian's Name \_\_\_\_\_  
( ) ( ) ( ) ( )  
Home Phone Work Phone Home Phone Work Phone

Address \_\_\_\_\_ Address (enter "same" if it is the same as first parent or guardian)

City, ST ZIP Code \_\_\_\_\_ City, ST ZIP Code \_\_\_\_\_

Email: \_\_\_\_\_ Email: \_\_\_\_\_

**Alternative Emergency Contacts**

Primary Emergency Contact \_\_\_\_\_ Secondary Emergency Contact \_\_\_\_\_  
( ) ( ) ( ) ( )  
Home Phone Work Phone Home Phone Work Phone

**Medical Information**

**ALLERGIES: (circle)** No Known Allergies This camper is allergic to: Food Medicine The Environment  
Please describe below what the camper is allergic to and reaction seen: If necessary, please attach another sheet.

\_\_\_\_\_  
\_\_\_\_\_

**RESTRICTIONS:**

- **Activities:**

Please explain what cannot be done, what adaptations or limitations are necessary:

\_\_\_\_\_  
\_\_\_\_\_

- **Dietary:**

Does not eat: (circle all that apply) Red Meat Fish Poultry Dairy Products

Other: \_\_\_\_\_

**HEALTH CARE PROVIDERS**

Primary Doctor Name: \_\_\_\_\_ Phone: \_(\_\_\_\_\_)\_\_\_\_\_

Dentist Name: \_\_\_\_\_ Phone: \_(\_\_\_\_\_)\_\_\_\_\_

Orthodontist Name: \_\_\_\_\_ Phone: \_(\_\_\_\_\_)\_\_\_\_\_

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<b>Parent Authorization for Health Care</b>
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The health history is correct and complete. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed and over-the-counter medications and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician/health care provider selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This complete form may be photocopied for trips out of camp. I understand this information will be shared on a "need to know" basis with camp staff. I give permission for any health care provider who treats my child to share medical information regarding my child's health status with the camp's medical staff for treatment purposes.

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Parent's/Guardian's Signature

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DATE: