Health History Form for Camp Cavaignac

*Please mail this form to Camp Cavaignac, P.O Box 88, Ryde, CA 95680

Camper Name: (last) ________________________ (first) _______________
Session: _______________ Dates of Attendance: ____________________________

Birthdate: __/__/____ Age at Camp ____ Male or Female (circle one)

Participant's Home address: Street: ____
City: ________________________ State: ____ Zip: ________

Custodial parent/guardian ____ Home Phone: _______________
Work Phone: _______________ Cell Phone: _______________ Email address: _____________________________
Home Address: (if different than above) Street:_____________________________ City: _________ State: ____ Zip: ________
Business Address: Street:______________________________ City: ____________________ State: ____ Zip: ________

Emergency contact, or second guardian: __________________________________ Home Phone: _______________
Work Phone: _______________ Cell Phone: _______________
Address: Street:______________________________ City: _______________________ State: ____ Zip: ________
Business Address: Street:__________________________ City: _______________________ State: ____ Zip: ________

If not available in an emergency, please notify:
Name: ____
Relationship: ____________________________ Home Phone: _______________ Work Phone: _______________
Cell Phone: _______________
Home Address: Street:______________________________ City: ______________________ State: ____ Zip: ________

Family Physician: ____ Phone: _____________________

Insurance Information
The participant is covered by family medical/hospital insurance. Yes _______
Carrier or plan name: _____________________________ Group # ______________________
Carrier Address: ____
Name of Insured: _________________________________ Relationship to Participant: _________________
Social Security number of policy holder or insurance ID number ___________________________
Important – These boxes must be complete for attendance!

Parent/Guardian Authorization: This health history is correct and complete as far as I know. 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 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 me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian or adult camper/staffer____

Printed name: ____ Date: ____________________________

Health History:

The following information must be filled in by the parent/guardian, or adult camper staff member. The intent of this information is to provide camp healthcare personnel the background to provide appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your camper's needs.

Allergies or Reactions. **List all known. Describe reaction and management of reaction**

Medication allergies (list)

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Food allergies (list)

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Other allergies (list) – include insect stings, hay fever, asthma, animal dander, etc.

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Medications Being Taken

Please list ALL medications (including over-the-counter, vitamins or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, dosage, and frequency of administration.

This person takes medications as follows:

Medication (list) Dosage Specified times taken each day Reason for taking medication

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Attach additional pages for more medications. Identify any medications taken during the school year that the participant does not take during the summer:

Please describe any behavior, physical or emotional, about which you would like the director and assistant director to be aware:

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This person takes NO medications on a routine basis ______________