

HEALTH FORM

CROSS ROADS CAMP & RETREAT CENTER

Camper Name: _____	Birth Date: ___/___/___
Program Name: DAY CAMP	Age: _____
Camper Address: _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Phone: (____) _____	

Parent/Guardian: _____ Home Phone: (____) _____

Address: _____ Work Phone: (____) _____

Name of Health Insurance*: _____ Group/Policy #: _____

Name of Parent Carrying Health Insurance: _____ Parent SS#: _____

**Please include a copy of the front and back of your insurance card*

If not available in an emergency, notify:

Name: _____ Phone: (____) _____

Name: _____ Phone: (____) _____

Name of Physician: _____ Phone: (____) _____

HEALTH HISTORY

To be completed by Parent/Guardian

Chronic Problems:

- Ear infections
- Asthma
- Diabetes
- Headaches
- Bedwetting
- Sleepwalking
- Learning Disability
- Psychiatric Care
- Seizures
- Other: _____

Describe Management of chronic problems and/or allergies: _____

Describe past medical treatments, surgeries, hospitalization, injuries, special restrictions, or considerations while at camp: _____

Describe treatment your son/daughter receives for emotional, learning, or psychological concerns: _____

Allergies:

- Food
- Medication
 - Penicillin
 - _____
- Insect Stings
- Hay Fever
- Other: _____

For Female: has this person menstruated? _____ If not, has she been told about it? _____
If so, is her menstrual history normal? _____ Special considerations: _____

Dietary Restrictions: _____

Immunization Dates:

- (month/year)
- ___/___ DPT series
 - ___/___ Mumps
 - ___/___ Measles
 - ___/___ Rubella
 - ___/___ Polio Series
 - ___/___ Hepatitis B Series
 - ___/___ Tetanus Booster

- | | | |
|---|------------------------------|-----------------------------|
| Is your son/daughter a vegetarian? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has your son/daughter had chicken pox? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has your son/daughter ever been to camp before? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has your son/daughter ever been homesick? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does your son/daughter wear glasses/contacts? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does your son/daughter have braces? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does your son/daughter wear a retainer? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Please list any medications and send with directions: _____