

FUNCAMPS

Office: 4000 Ponce De Leon Blvd. Suite #470, Coral Gables, Fl. 33146

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HEALTH AND EMERGENCY CONTACT FOR CAMPERS

This form must be completed for EACH CHILD and submitted before June 1st, 2009.

It DOES NOT need to be completed by a physician. Important: If camper is 6 years of age, Dade County Department of Health requires us to have a PHYSICIAN SIGNED copy of current (within one year of 5/29/08) Certificate of Good Health (HRS Form 3040), Fla. Cert. Of Immunization, Inc. a TB test (HRS Form 680).

Camper's Name _____ Age _____ M/F _____

EMERGENCY CONTACTS:

Mother, Guardian, Co parent

Name _____
Home Phone _____
Business phone _____
Other Phone _____

Father, Guardian, Coparent

Name _____
Home Phone _____
Business phone _____
Other Phone _____

Other Contacts

Name _____
Relationship to camper _____
Home Phone _____

City _____
Business Phone _____
Other Phone _____

Physician's Name _____
Dentist's name _____

Physician's phone _____
Dentist's _____

Date of last physical exam _____ Do you carry family medical/hospital insurance? Yes ___ No ___ If so, indicate carrier _____ Policy/Group _____

Acetaminophen (non aspirin compound) can be given for a temperature above 100 degrees, earache, headache, or menstrual cramps. Yes ___ No ___

Benadryl can be given for insect bites/rashes/itching. Yes ___ No ___

HEALTH HISTORY Check and give approximate dates when applicable.

_____ Measles	_____ Heart Defect/Disease	_____ Convulsions
_____ Frequent Ear Infections	_____ Bleeding/Clotting Disorders	_____ Hypertension
_____ Chicken Pox	_____ Diabetes	_____ Asthma (or inhaler? _____)

ALLERGIES Check all that apply

_____ Penicillin _____ Insect Stings _____ Poison Ivy _____ Hay Fever _____
_____ Food Allergies Please list all foods _____
_____ Other (please describe) _____

IMMUNIZATION RECORD Provide approximate dates

_____ DPT (Diphtheria, Pertussis, Tetanus)	_____ DT (Tetanus Diphtheria)	_____ or Tetanus
_____ Rubella (German or three day measles)	_____ Oral Polio (Sabin)TOPV	_____ Injectable Polio (Salk)
_____ Tuberculin test given (date)	_____ Hepatitis B	_____ Mumps
_____ Measles (Hard measles, red measles, Rubella)	_____ Other (please describe)	_____

MEDICAL INFORMATION

Operations or serious injuries _____
Chronic or recurring illness or medical condition _____
Dietary restrictions _____
Current medications _____
Medications taken during the school year _____

RELEASE: This statement must be signed for attendance. This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities as noted. **AUTHORIZATION FOR TREATMENT:** I hereby give my permission to the medical personnel selected by the camp director to order X-rays, treatments, and release of any records necessary for insurance purposes and to provide or arrange any transportation for my child (camper) in the event I cannot be reached in emergency. I hereby give my permission to the physician selected by the camp director to secure and administer treatment including hospitalization for the above-named person.

_____ sign here

_____ date