

Camp Shutout West Michigan Camper Medical Form

Camper Name: _____ Date of Birth: _____ Phone Number: _____

Contact if the parent/guardian can't be reached: _____ Relationship: _____ Phone Number: _____

Medical Information: Does the camper currently have or have they ever had any of the following:

	Yes	No	Specific Information		Yes	No	Specific Information
Heart Murmurs	<input type="checkbox"/>	<input type="checkbox"/>	_____	Inhalers (types)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Irregular Pulse	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heat Exhaustion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heat Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heat Cramps	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Fractures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____	Muscle Injuries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____	Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____				

Rx

Medications (medication, dosage, indications, physician's name): _____

Has camper ever sustained a head or spinal injury? If yes, please explain injury and cause of injury: _____

Have camper ever lost consciousness? _____

Do you have any other medical problems that could interfere with full participation in physical activities? If yes, please explain:

This is to certify that _____ has been examined by a physician within the past year, and was found to be physically able to participate in vigorous physical activity and competitive athletic sports.

Parent/Guardian Signature: _____

Insurance Information

Policy Holder: _____ Policy Holder DOB _____

Relation to Child: _____

Name of group employer: _____

Insurance Company: _____

Policy #: _____ Insurance ID #: _____ Group #: _____

I hereby authorize the directors and medical staff of Camp Shutout and Clark Keeper Training to act for me according to their best judgment in any emergency requiring medical attention. I understand that first aid procedures will be rendered by the training staff, and campers will be transported to a hospital if necessary. I hereby waive and release Camp Shutout, Clark Keeper Training and staff for liabilities relation to injury, illness, or expenses incurred. I know of no mental or physical problems which might affect my child's ability to safely participate in this camp. I will be responsible for any medical or any other charges in connection with their attendance at camp.

Parent/Guardian: _____ Parent/Guardian Signature: _____ Date: _____