# Camper Health and Medical History

To be filled out by a parent or guardian. Please print in ink.

**Identification**

Camper Name:_____ Date of Birth:_____
Age:_____Sex:_____
Hometown: _____

Email address: _____ Can we add you to our mailing list? __Yes __ No

Parent Contact Name_____Telephone:_____
Telephone #2:_____

If person named above in not available in the event of an emergency, notify:

Name_____Relationship_____Telephone_____

Name_____Relationship_____Telephone_____

**Insurance Information:**

Is participant covered by family medical/hospital insurance? YES NO

Personal health/accident insurance carrier_____Policy no_____

**Authorizations:**

I give permission for full participation in Nevada Outdoor School programs, subject to limitations noted herein.

In case of an emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the Medic, Assistant Medic or the licensed health care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child.

Printed Name:_____

Signature of parent/guardian:_____Date_____

**ALLERGIES:** List all known. Describe reaction and management of the reaction.

Medication allergies (list)

_____

_____

Food allergies (list)

_____

_____

Other allergies (list)—including insect stings, hay fever, asthma, animal dander, etc.

_____

_____

**Restrictions:**
Cannot eat: __Red Meat __Pork __Dairy Products __Poultry __Seafood __Eggs
__Other (please describe) _____

List any physical or behavioral conditions that may affect or limit full participation in activities such as swimming, hiking long distances, or kayaking (e.g. what cannot be done, what adaptations or limitations are necessary):_____

_____

**MEDICATIONS:**

Please list ALL medications (**including over-the-counter or nonprescription drugs**) taken routinely. Bring enough medication to last the entire time at camp. Keep drugs in their original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. Parent or Guardian understands that the medications will be held by a NOS staff member and dosage given to a child as required. Campers will not keep the medications themselves during camp.

_____ This person takes NO medication on a routine basis OR
_____ This person takes medications as follows:

Med #1:_____
Dosage_____
Specific times taken each day_____
Reason for taking_____

Med #2:_____
Dosage_____
Specific time taken each day_____
Reason for taking_____

**Does the Camper have/use:**

_____Inhaler
_____Epi-Pen
_____Insulin or other diabetic medications
_____Severe allergic reactions to anything
_____History of bed-wetting

Please explain any checked boxes above:

_____

_____

Name of personal physician_____Telephone_____

Name of family dentist/orthodontist_____Telephone_____

**Immunizations:**

I certify that my child has their immunizations up to date.
SIGNATURE REQUIRED:_____

**Additional Information:**

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

_____

_____