

Camp Shalom

Health History and Pick Up Authorization

Child's Last Name	First Name	M.I.	Home Phone #
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Home Address	City, Zip Code
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Mother's Name	Business Phone #	Cell Phone #	Email Address
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Father's Name	Business Phone #	Cell Phone #	Email Address
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Please list at least two people to call (other than parents) in an emergency:

Name	Relationship to Child	Home #	Cell #
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Name	Relationship to Child	Home #	Cell #
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Name	Relationship to Child	Home #	Cell #
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Important — These boxes must be complete for attendance*

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

of any records necessary for treatment, referral, billing, or 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.

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

Signature of parent or guardian or adult camper/staffer _____
 Printed name _____ Date _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor or adult camper/staffer _____ Date _____

**If for religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.*

ALLERGIES List all known.

Describe reaction and management of the reaction.

Medication allergies (list)

Food allergies (list)

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



MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter 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, the dosage, and the frequency of administration.

This person takes **NO** medications 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 times taken each day _____
 Reason for taking _____

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

RESTRICTIONS (The following restrictions apply to this individual.)

Does not eat: Red meat Pork Dairy products Poultry Seafood Eggs Other (describe) _____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary) _____

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. _____

Name of family physician _____ Phone _____
 Address _____

Name of family dentist/orthodontist _____ Phone _____
 Address _____

THE FOLLOWING PEOPLE HAVE MY PERMISSION TO PICK UP MY CHILD.

Please print the names of everyone allowed to pick up your child, including parent's names.

Name	Home #	Cell #	Work #
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

Signature of Parent/Guardian _____ Relationship to Child _____ Date _____

PASSWORD

Please write a password on this line.
 Pick a password that you can easily remember, and make sure everyone on this list knows your password.