

ELEVATE CAMPS HEALTH AND ACTIVITY RECORD

Please complete, sign, and date this form for all campers. Do not mail. Do not fax. Form must be turned in upon arrival. (If form is incomplete, parents or quardian will be called collect.)

Please Print

		1 1		9							
Last Name			First Name			Middle Initial					
Date of Birth				Male Female		Dates	ates Attending Camp				
Group Information	on:										
Group Name				Group Lead			Leader				
Leader Phone Number: Home ())		Work ()	Cell ()			
	Full N	lame:					Telephone I	Telephone Numbers With Area Codes			
Parent or Guardian					Home (Home ()					
	Addr	ess			Work (Work ()					
	City				State		Zip code				
	Emai	nail:									
If not available in an emergency notify: (preferably relatives)							Telephone	Telephone Numbers With Area Codes			
Name							()				
Name							()				
	Name of Co	mpany				Policy/Group Number					
Family											
Health		Contact Per	son			Telephone Number					
Insurance Information					())					
		Parents/Guardian (Required by Medical Facilities if under 18 years old)									
	Parent/Guai	dian Nam	е								
Special medica	l prob	ems, conditi	ons or re	strictions:							
List medicines? medications <u>m</u> u					s, including vi	tamins,	ylenol, etc, be given to	the camp nurse. All			
Medications all Penicillin	ergic 1 Sulfa		he count Aspirin		ns your camp (Please list)	oer may	ot have:				
Any food allerg	gies?	YES () NO If	yes, explain							
Is child trouble	d with	bed-wetting	g? ○Y	es Ono							
Able to pursue	all no	rmal athletic	activities	? YES	○NO If I	no, expla	in.				

If Compar has has	d any of the following please	shock the box s	and include year	occurred:											
ii Camper nas nac		Asthma	and include year		Bronchitis										
		Chorea			Chronic Intestinal Problems										
		Diphtheria			Eczema										
Ir		Epilepsy			Frequent Colds										
			oro Throats		HIV Positive										
N		Frequent Sore Throats HIV Positive Hives													
			ory Bowel Diseas		Kidney Disease										
"		Malaria	bry bower biseas		Kidney Disease										
N	nepatitis	Mononucle	a a i a												
					Mumps Otitis Media										
		Orthopedia			Rheumatoid Arthritis										
		Polio Myeli Rubella (Ge													
K					Scarlet Fever										
		Speech De		10	Tuberculosis or TB Contact										
V	enereal Disease	Whooping	Cougn												
	ation, required by law, must o			to those diseas	es, dates and d	oses.									
	Immunizations must be updated if not in accordance with state regulations.														
	Measles means two doses of														
(preferab	ly three months), and/or a ph	ysician-docume	nted history of t	he disease or se	erologic evidenc	e of									
	immunity.														
O Proof of F	Rubella means one dose of ru	bella vaccine or	n or after your fii	rst birthday or s	erologic eviden	ce of									
immunity															
O Proof of I	Mumps means one dose of m	umps vaccine o	n or after your fi	rst birthday, a p	hysician-docum	ented history									
of the dis	ease, or serologic evidence o	of immunity.		of the disease, or serologic evidence of immunity.											
IMMUNI	ZATION HISTORY	1st Dose	2nd Dose	3rd Dose	4th Dose	Last Dose									
		1st Dose	2nd Dose	3rd Dose	4th Dose	Last Dose									
Diphtheria & Tetanus	TATION HISTORY Toxoid DT Five or more doses dose must be within 10 years	1st Dose	2nd Dose	3rd Dose	4th Dose	Last Dose									
Diphtheria & Tetanus	Toxoid DT Five or more doses	1st Dose	2nd Dose	3rd Dose	4th Dose	Last Dose									
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Date:

Date:

Signature of Father/Guardian(s):

Signature of Mother/Guardian(s):