Discovery Camp 2009 Individual Registration and Health Form

Camp dates attending: Arrive:_____/_____/_____ Depart: _____/_____/_____
Have you ever attended Discovery Camp before? ☐Yes ☐No

(This side to be filled in by parents/guardian of minor or by adult campers/staff members themselves.)
DO NOT FAX THIS IN

Name: |___|___|___|___|___|___|___|___|___|___|___| |___|___|___|___|___|___|___|___|___|___| |___|
last first initial

Birthdate _____/_____/_____ Sex: ☐ M ☐ F Age: |___|___|

Church Name: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

(For ages 17 and under)

Both Parents or Guardians (or Spouse):

1: |___|___|___|___|___|___|___|___|___|___|___|___| |___|___|___|___|___|___|___|___|___|___|___|___|
last first

Home Address: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

|___|___|___|___|___|___|___|___|___|___| |___|___| |___|___|___|___|___| |___|___|___|-|___|___|___|-|___|___|___|___|
city state zip phone

2: |___|___|___|___|___|___|___|___|___|___|___|___| |___|___|___|___|___|___|___|___|___|___|___|___|
last first

Home Address: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

|___|___|___|___|___|___|___|___|___|___| |___|___| |___|___|___|___|___| |___|___|___|-|___|___|___|-|___|___|___|___|
city state zip phone

If not available in an emergency, notify:

|___|___|___|___|___|___|___|___|___|___|___|___| |___|___|___|___|___|___|___|___|___|___|___|___|
last first

Home Address: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

|___|___|___|___|___|___|___|___|___|___| |___|___| |___|___|___|___|___| |___|___|___|-|___|___|___|-|___|___|___|___|
city state zip phone

Health History:

check & give approximate dates

_____ ☐ Frequent ear infections
_____ ☐ Heart defect/disease
_____ ☐ Convulsions
_____ ☐ Diabetes
_____ ☐ Bleeding/Clotting disorders
_____ ☐ Hypertension
_____ ☐ Mononucleosis
_____ ☐ HIV-AIDS
_____ ☐ TB
_____ ☐ Cancer

Allergies

☐ Hay Fever
☐ Ivy Poisoning, etc.
☐ Insect stings
☐ Penicillin
☐ Other Drugs
☐ Asthma
☐ Other (specify) _____
_____

Has this camper ever required any psychiatric counseling or hospitalization? ☐Yes ☐No
Explain: _____
Operations or serious injuries (dates) _____
Disability or chronic or reoccurring illness: _____
Activities encouraged or limited by physician: _____
Dietary Modifications: _____
Current Medications (send with instructions): _____
_____
Name of dentist/orthodontist: _____ Phone: (____)_____
Name of family physician: _____ Phone: (____)_____
Do you carry family medical/hospital insurance? ☐Yes ☐No
If so, indicate: Carrier _____
Policy or Group # _____ Phone: (_____)_____
Suggestions on health related information for camp personnel _____
_____

For Female Only

Has this person menstruated? ☐Yes ☐No If not, has she been told about it? ☐Yes ☐No
If so, is her menstrual history normal? ☐Yes ☐No Special Consideration: _____
_____