CAMP LAWRENCE
HEALTH FORM

(Bring this form with you to Camp Lawrence on day of registration.)

This side is to be filled out by parent or guardian *and checked by physician at time of examination.*

(PLEASE PRINT)

Name_____
Birthdate_____Age_____Phone _____
Parents Name(s) _____ Parents Work #_____ CellPhone#_____
Full Address_____
Emergency Contact Person_____Phone_____
Address_____Relationship to you_____
Health Insurance Company:_____Policy # _____

HEALTH HISTORY

IS CAMPER SUBJECT TO OR HAD:	YES	NO	EXPLANATION, DATES, ETC.
Ear infections (including swimmers ear)			
Bedwetting			
Unusual reactions to insect bites			
Hay fever			
Unusual sensitivity to poison ivy, etc.			
Epilepsy (convulsions)			
Asthma			
Diabetes			
Heart disease (rheumatic, congenital)			
Allergies (penicillin, aspirin, other medication; food)			
Operations or serious injuries (specify dates)			
Serious or chronic illnesses other than above			
Mental or Psychological Conditions			

PARENT AUTHORIZATION, RELEASE AND WAIVER OF RESPONSIBILITY
(*Must be signed and dated or application will not be accepted.)*

This health history is correct so far as I know and the person herein described has permission to engage in all prescribed activities except as noted by the examining physician and me. In the event of an emergency, I hereby give my permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above. I hereby, for myself, my heirs, executors and administrators, waive and release any and all rights and claims for all loss or damages I may have against the CYO and Camp Lawrence and their representatives for any and all injuries suffered by me at camp.

I also give permission for the free use of my name and/or picture in any broadcast, telecast or other account of CYO events.

Signature_____ Date_____

THIS SIDE TO BE FILLED OUT BY THE ATTENDING PHYSICIAN.			
IMMUNIZATIONS	YES	NO	DATE
Measles			
German Measles (Rubella)			
Mumps			
DPT series			
Tetanus (most recent)			

For females only: Has camper menstruated?_____ If so, has menstrual history been normal?_____
If camper has not started, has camper been told about it?_____

HGT_____ WHT_____ BL. PR_____/_____ HGB (if indicated)_____Urinalysis (if indicated)_____

	SATISFACTORY	NOT SATISFACTORY (explain)
Eyes		
Glasses/contacts		
Ears		
Nose		
Throat		
Teeth		
Heart		
Lungs		
Abdomen		
Hernia		
Extremities		
Posture (spine)		
Skin		

RECOMMENDATIONS AND/OR RESTRICTIONS WHILE AT CAMP:

Special diet	
Medications (dosage & schedule)	
Swimming, diving, hiking, etc.	
Strenuous activity	
Other	

General appraisal of camper:_____
_____
_____

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in all camp activities except as noted above.

Physician's signature____Printed name_____ Exam Date_____
Physician's Address/Phone _____