MEDICAL FORM

Hiram House Camp
33775 Hiram Trail
Chagrin Falls, Ohio 44022

Telephone: (216) 831-5045
FAX: (216) 831-2477

Resident Camp ☐ Day Camp ☐ Jr. Day Camp ☐

Adventure Camp ☐

Session dates of attendance _____

Camper Name _____

PLEASE COMPLETE AND RETURN AT LEAST TWO WEEKS BEFORE CHILD ATTENDS CAMP.
THIS FORM **MUST** BE COMPLETE IN ORDER FOR CHILD TO ATTEND CAMP. The second page of this form must be completed and signed by a licensed medical practitioner.

Name of family physician_____ Phone _____

Fax _____

Name of family dentist/orthodontist_____ Phone _____

Fax _____

INSURANCE INFORMATION

Is the participant covered by family medical / hospital insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name _____ Group # _____

Carrier address _____

Name of insured _____ Relationship to participant _____

Social security number of policy holder or insurance ID number _____

Important - The Permission boxes must be completed for attendance*

Permission to Provide Necessary Treatment or Emergency Care :

I, _____, the legal guardian of _____, give my permission for him/her to participate in the program and activities. I understand the staff is not responsible in the event of accidental injury or illness, nor for compounded injury or illness to present conditions noted herein. I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for named participant. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. I understand that The Hiram House is not responsible for costs incurred for medical care.

Signature of parent/guardian _____ **Date** _____

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

Camper Agreement

I understand and agree to abide by the restrictions placed on my camp activities.

Signature of camper _____ **Date** _____

Camper Name_____

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Which of the following has the participant had?

☐ Measles date _____
☐ Chicken Pox date _____
☐ German Measles date _____
☐ Mumps date _____
☐ Hepatitis date _____

TB Screening
Date of last screening _____
Result: ☐ Positive ☐ Negative

Please give all dates of immunization for:

Vaccine:	**Dates:**	**Mo/Yr**	**Mo/Yr**	**Mo/Yr**	**Mo/Yr**	**Mo/Yr**
DTP		_____	_____	_____	_____	_____
TD (tetanus/diphtheria)		_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____
MMR		_____	_____			
or Measles		_____	_____			
or Mumps		_____	_____			
or Rubella		_____	_____			
Haemophilus influenza B			_____	_____	_____	_____
Hepatitis B			_____	_____	_____	
Varicella (chicken pox)		_____	_____			
BCG		_____				

HEALTH CARE RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL

I have examined the camp participant herein described. Date of examination _____/_____/_____

BP _____ Weight _____ Height _____

In my opinion, the applicant ☐ IS ☐ IS NOT able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:_____

_____

Current treatment at the time of this report includes:_____

_____

Recommendations and Restrictions at Camp

Treatment to be continued at camp: _____

_____

Medications to be administered at camp (name, dosage, and frequency): _____

_____

Known allergies: _____

_____

Any medically-prescribed meal plan or dietary restrictions: _____

_____

Description of any limitation or restriction on camp activities: _____

_____

Additional information for health care staff at camp: _____

Signature of Licensed Medical Personnel_____

Printed _____ Title _____ Date _____

Address _____ Phone _____

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