

Medical forms must be in the city office by May 1, 2009.

WE ARE REQUIRED BY LAW TO HAVE THIS COMPLETED FORM AT CAMP IN ORDER FOR YOUR CHILD TO BOARD THE BUS.

CAMPER'S NAME _____ GRADE AS OF SEPT. '09 _____ SEX _____
 PARENT'S OR GUARDIAN'S NAME _____ CAMPER'S DATE OF BIRTH _____
 HOME ADDRESS _____ CITY _____
 STATE _____ ZIP _____ COUNTRY _____ HOME PHONE _____
 BUSINESS PHONE: MOTHER _____ FATHER _____
 CELL PHONE: MOTHER _____ FATHER _____
 INSURANCE COMPANY _____ POLICY # _____ GROUP/ID # _____
 NAME OF POLICY HOLDER _____ RELATION TO CAMPER _____
 NAME OF DOCTOR _____ PHONE _____
 NAME OF DENTIST _____ PHONE _____

Program: Mini A Session 1 Super Season Agree Western
 Mini B Session 2 TSS/Hadracha Kennedy Alaska

PARENTS OF 8TH GRADERS, PLEASE ALSO CHECK: Village: Pioneer Ruach **Session:** 1 or 2 only;
OR, Super Season: Pioneer/Ruach Ruach/Pioneer Ruach/Ruach

Please check if camper had any trouble within the last year. Explain below.

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Bone/Muscle Problems	<input type="checkbox"/> Ear Trouble	<input type="checkbox"/> Seizures
<input type="checkbox"/> Allergies	<input type="checkbox"/> Constipation	<input type="checkbox"/> Headaches	<input type="checkbox"/> Skin Problems
<input type="checkbox"/> Asthma (breathing problems)	<input type="checkbox"/> Depression	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Strep Throat
<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Nightmares/Sleepwalk	<input type="checkbox"/> Other _____

Explanation of above and additional medical/psychological/emotional information that is important for us to know (if necessary, please attach a separate sheet of paper):

IN CASE OF EMERGENCY (IF PARENT CANNOT BE REACHED):

_____	HOME # _____	CELL/BUSINESS # _____
NAME AND RELATIONSHIP		
_____	HOME # _____	CELL/BUSINESS # _____
NAME AND RELATIONSHIP		

NAMES OF PERSONS OTHER THAN PARENT TO WHOM CHILD MAY BE RELEASED:

_____	RELATIONSHIP _____	PHONE # _____
NAME		
_____	RELATIONSHIP _____	PHONE # _____
NAME		

HEALTH AND SAFETY AGREEMENT:

Camp has my permission to provide routine, non-surgical medical care to my child. In the event of a medical emergency and I cannot be reached, I hereby give permission to the physician selected by the camp director or his/her agent to hospitalize, secure treatment for, and to order injections, anesthesia or surgery for my child as named herein. I also understand that I am responsible for the costs incurred on behalf of my child relating to accident or illness when treated outside of camp. Although the fullest safety precautions are taken, the camp does not assume responsibility for any accident. I give permission to the camp director or other designated staff member to contact anyone treating the child for emotional reasons. The information obtained from such person will only be used to provide for the welfare of the child at camp. I have read all of the registration materials, policies, guidelines and details provided by the camp and agree to abide by the requirements set forth therein. I understand that my child will not be allowed to take medication from home unless it is ordered by a physician, or parent in the case of over-the-counter medication, and noted in writing on the Medication Information form. I hereby accept and agree to abide by the provisions of the Health and Safety Agreement.

 PARENT/GUARDIAN NAME (Please print) PARENT/GUARDIAN SIGNATURE DATE

REVERSE SIDE TO BE COMPLETED BY PHYSICIAN

THIS SIDE TO BE COMPLETED BY LICENSED PHYSICIAN OR DESIGNEE

Your doctor's office must complete this side of the form using the medical information from a physical examination conducted anytime between August 2007 and May 2009.

CAMPER'S NAME _____ GRADE AS OF SEPT. '09 _____ SEX _____
Birth Date _____ Height _____ Weight _____ Blood Pressure _____ Heart Rate _____

CAMPER ALLERGIES (Please note we are not a nut-free camp):

NONE MEDICATIONS FOOD POLLENS, GRASSES, TREES, ETC. OTHER

PLEASE EXPLAIN: _____

Please Indicate Date:

Last Tetanus _____

Last MMR _____

Has Camper Had Chicken Pox Disease? Yes No

or vaccine: _____
Date

Has Camper Had Menactra Meningitis Vaccine?

Yes No

Date

PLEASE ENSURE THAT IMMUNIZATIONS ARE UP TO DATE BEFORE CHILD ATTENDS CAMP.

HAS THE CAMPER HAD ANY SURGERY? – IF YES, PLEASE LIST WITH DATES _____

ANY RESTRICTIONS OR LIMITATIONS CAMPER MUST OBSERVE? _____

ANY MEDICAL CONDITIONS CAMPER IS BEING TREATED FOR? _____

PRESENTLY, IS CAMPER TAKING ANY MEDICATION (INCLUDING ALLERGY)? DURING SUMMER? IF YES, LIST:

REASON:

PLEASE INDICATE WHETHER THE CHILD HAS ANY EMOTIONAL, PSYCHOLOGICAL OR NEUROLOGICAL PROBLEMS AND EXPLAIN. _____

(FEMALE CAMPERS)

ONSET OF MENSTRUATION? Yes No

ARE PERIODS REGULAR? Yes No

PAINFUL? Yes No

This information will remain confidential and will only assist us in providing your child with a quality experience.

I have examined the above applicant for entrance to the Tamarack Camps and find him/her physically qualified to be accepted as a camper and to enter into all camp activities including canoe and extended hiking trips away from camp, except with the restrictions stated above.

SIGNED _____ DATE OF MOST CURRENT EXAM _____
(EXAMINING PHYSICIAN)