

Camp DISCOVER 2025

HEALTH INFORMATION FORM

Last Name: _____ First Name: _____ Birthdate: ____/____/____

HEALTH HISTORY: (Check any condition a staff member should know about)

____ Heart Condition ____ Diabetic ____ Asthma
____ Allergic to Bee Stings ____ Food Allergies _____
____ Allergic to Nut Products ____ Allergies to Medication _____
____ Other known health condition: _____

Is the camper taking any medication? (Prescribed or over-the-counter) ____ No ____ Yes

If yes, name of medication: _____ (send only what will be needed at camp)

My Child has no known health conditions at this time

- I authorize the camp leaders to dispense over-the-counter (non- prescription) medications as deemed necessary (eg. Benadryl, Tylenol, Non-steroidal Anti-inflammatory, Cortisone Cream, Neosporin, etc.) during my child's attendance at camp with these exceptions:

- Inhalers and Epi-pens may be carried by the individual for self-administration if child is able and willing to administer as prescribed. **YES/NO**
- Describe Food Allergies and Reaction:

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

PRINT NAME _____ **CONTACT PHONE #** _____

