

MEDICAL FORM PART A 2023

For both Resident & Day Campers

(This form must be completed by Parents/Guardians of Minors)

NAME: _____

Last First Middle
DATE OF BIRTH: (M/D/Y) _____ AGE: ____ HEIGHT: ____ WEIGHT: ____

CONTACT INFORMATION

ADDRESS: _____
 Street City State Zip Code Country

(____) _____

Home Phone (Area Code + #)

Father's Name: _____ Mother's Name: _____

Work Phone: (____) _____ Work Phone: (____) _____

Cell Phone: (____) _____ Cell Phone: (____) _____

E-mail: _____ E-mail: _____

Alternate Emergency Contact's Name 1: _____ Phone (____) _____

Alternate Emergency Contact's Name 2: _____ Phone (____) _____

Insurance Carrier: _____ Policy (____) _____

Under whose name is the insurance listed? _____ Group# _____

BASIC IMMUNIZATION HISTORY

HEALTH HISTORY

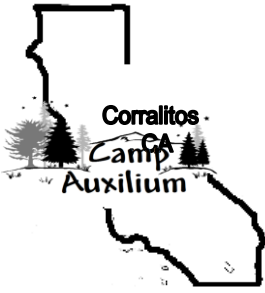
PLEASE ATTACH A COPY OF THE CAMPER'S INSURANCE CARD TO THIS MEDICAL FORM, SHOWING BOTH FRONT AND BACK SIDES OF THE CARD, AS WELL AS INFORMATION ABOUT SHOTS. IF YOU HAVE MEDICAL INSURANCE, YOUR CARRIER WILL BE BILLED FOR YOUR MEDICAL CHARGES IN CASE OF ILLNESS OR INJURY WHILE YOUR CHILD IS AT CAMP.

Vaccines	1 st	2 nd	3 rd	4 th	5 th	6 th
DPT (Diphtheria, Pertussis, Tetanus)						
TD (Tetanus/ Diphtheria)						
OPV or IPV (Oral Polio Vaccine)						
MMR (Measles, Mumps, Rubella)						
TB Skin Test						
HIB - Hemophilus influenza B						
HEPATITIS A						
HEPATITIS B						

	Yes	No
Asthma		
Chicken Pox		
Diabetes		
Ear Infection		
Heart Problems		
Measles		
Mumps		
Hepatitis		

MEDICAL FORM PART B 2023

For both Resident & Day Campers
(This form must be completed by Parents/Guardians of Minors)



CAMPER'S NAME: _____
Last First Middle

RESTRICTIONS:

1. Dietary Restrictions/Food Allergies

2. Restriction of Camp Activities

HEALTH CARE RECOMMENDATION BY A LICENSED PHYSICIAN

1. Medical conditions under care of physician

2. Treatment needed during camp

3. Known Allergies

4. Medication to be administered:

Name of medication	When to be taken?	Dosage
_____	_____	_____
_____	_____	_____

ALL PRESCRIPTION MEDICATIONS MUST BE ACCOMPANIED BY PHYSICIANS' INSTRUCTIONS (ON LABEL OF MEDICATION OR BY SEPARATE, SIGNED, TYPEWRITTEN INSTRUCTIONS.)

5. Surgeries, serious injuries or fractures (when?)

6. Any behavioral problems or concerns we need to know.

FEMALE APPLICANTS: Has she menstruated? _____ If not, has she been told about it? _____

IMPORTANT: We regret that due to safety and hygiene issues, Camp Auxilium is unable to accommodate children who sleepwalk or wet the bed.

Request for Administration of Medications by Camp Personnel

CAMPER'S NAME: _____
Last First Middle

This health information is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted.

DATE OF BIRTH: (M/D/Y) _____ AGE: _____ Grade next year _____

In the event that my child suffers from any mild pain or discomfort, I allow that over-the-counter medication be administered to my child at the discretion of the staff of Camp Auxilium. I understand that if the pain or discomfort persists, the staff of Camp Auxilium will contact me regarding my child's condition.

1. Please list any over-the-counter medications that your child **cannot** take.

2. List any regular over-the-counter medications you give to your child.

I waive any and all claims for damages against the SALESIAN SISTERS and/or CAMP AUXILIUM and/or the Diocese of Monterey, which I may have or which may hereafter accrue to me or my child, as a result of the administering of medicine. I intend and agree to release and discharge in advance the SALESIAN SISTERS and/or CAMP AUXILIUM and/or the Diocese of Monterey, and its officers, agents and employees, from any and all liability relating to the administration of said medications.

Parent/Guardian Signature _____ Date _____
() () ()
Home Number Work Number Cell Number

