

**Camp Jeremiah Johnson**  
**Health and Medical History Form**

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_

Name of parent or guardian \_\_\_\_\_

Telephone (where parent or guardian can be reached during hours of camp) \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_

If person named above is not available in the event of an emergency, notify:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

Name of personal physician \_\_\_\_\_ Telephone \_\_\_\_\_

Personal health/accident insurance carrier \_\_\_\_\_ Policy No. \_\_\_\_\_

Check all items that apply: past or present . Please provide details if conditions exist.

ALLERGIES:  food  medicines  insects  plants  None

\_\_\_\_\_

ADHD (Attention Deficit Hyperactivity Disorder)  Asthma  Cancer/leukemia  Kidney Disease  
 Diabetes  Convulsions/seizures  Heart Trouble  Hemophilia  High Blood Pressure  Other

\_\_\_\_\_  
\_\_\_\_\_

List any medications you are currently taking: \_\_\_\_\_

List any medications to be taken at camp: \_\_\_\_\_

List any physical or behavioral conditions that may affect or limit full participation \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc. \_\_\_\_\_

\_\_\_\_\_

Immunizations: (Give date of last inoculation if known or state if immunizations are current)

Tetanus \_\_\_\_\_ Measles \_\_\_\_\_ Mumps \_\_\_\_\_ Polio \_\_\_\_\_

Diphtheria \_\_\_\_\_ Pertussis \_\_\_\_\_ Rubella \_\_\_\_\_ Other \_\_\_\_\_

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I give permission for full participation in BSA programs, subject to limitations noted herein. In case of emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or me, if an adult).

Parent Signature

Date