Camp Jeremiah Johnson
Girls Program 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