



# Health History and Permission Form

## Camp Just Imagine

### June 2008



Camper Information

Name \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Name of Parent/Guardian \_\_\_\_\_

Telephone number where you may be reached during camp hours \_\_\_\_\_

Emergency Contact (other than the listed Parent/Guardian) \_\_\_\_\_

Cell # \_\_\_\_\_ Other phone # \_\_\_\_\_

Medical History (Please check/complete all that apply)

Previous Diseases	Significant Allergies (specify)	Chronic or Recurring Illness		
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Food: _____	<input type="checkbox"/> Asthma	<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Measles	<input type="checkbox"/> Medicine/Drug: _____	<input type="checkbox"/> Heart Defect	<input type="checkbox"/> Seizures	<input type="checkbox"/> Digestive
<input type="checkbox"/> German Measles	<input type="checkbox"/> Plant/Pollen: _____	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Ear Infections	
<input type="checkbox"/> Mumps	<input type="checkbox"/> Insect Sting: _____	<input type="checkbox"/> Skin Condition		
Other: _____				

Other Health Concerns (please attach explanations as needed)

<input type="checkbox"/> Frequent nosebleed	<input type="checkbox"/> Physical or mental impairment: _____
<input type="checkbox"/> Frequent headaches	<input type="checkbox"/> Previous operation/hospitalization: _____
<input type="checkbox"/> Dizzy spells/fainting	<input type="checkbox"/> Bone/joint injury in the past 12 months: _____
<input type="checkbox"/> Visual impairment	<input type="checkbox"/> Major illness in the past 12 months: _____
<input type="checkbox"/> Hearing impairment	<input type="checkbox"/> Other: _____

**MUST** complete and sign other side/page 2

Attach copy of Immunization Record



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Medications (please attach additional pages as necessary) **ALL** medications brought with the camper must be in the original container with all labels intact, and must be listed on this page. Prescription labels must have the camper's name and current dosage. Dosage of non-prescription medication may not exceed product recommendation without doctor's written orders.

Medication	Dosage	Frequency	Reason
1. _____			
2. _____			
3. _____			

Health Care and Camp Permission (Parent/Guardian must initial and sign the statements below)

\_\_\_\_\_ I give permission for Texas PTA Camp staff to administer the medications listed on the previous page to my child/ward. No other medications will be administered without my specific written permission.

\_\_\_\_\_ I give my permission for first aid techniques and simple health care to be administered as the need arises. I understand in the event of any serious injury or illness on the part of my child/ward, the camp officials will make all attempts to contact me at the telephone numbers provided in this document, but reserve the right to seek professional medical attention including but not limited to consultation with Emergency Medical Services and emergency transportation.

I hereby attest that all information listed on this form is complete and accurate to the best of my knowledge and that my child/ward is in acceptable health, physical ability, and emotionally ready to fully participate in camp activities. I grant my permission as the parent/guardian of the camper mentioned on this form to participate in all activities associated with the enrolled event with the exceptions that are noted by myself or physician.

Parent/guardian signature \_\_\_\_\_ Date \_\_\_\_\_