Camp Wyoming 9106 42nd Ave. Wyoming, IA 52362 563-488-3893

Camp Wyoming Health Form

To be completed by PARENT/GUARDIAN

Camp Session:________________________________Camp Date:______________________

Camper Name:__________________________Age:________DOB:_____________Sex:_____

Address:____
Street City State Zip

Parent/Guardian:_________________________________Phone:_____________________

2nd Parent/Guradian:______________________________Phone:_____________________
(if applicable)

Emergency Contacts:

1. Name:____________________________Relationship:______________Phone:____________

2. Name:____________________________Relationship:______________Phone:____________

Insurance Information:

Carrier or Plan Name:____

Group:____

Insurance Company Mailing Address:____
(Address, City, State, Zip)

Name of Insured:_____________________ Relationship to Participant:____________________

SS# of Policy Holder or Insurance ID#:____

Family Physician:____Phone:________________

Family Dentist:____Phone:________________

Current Medications to be taken at camp: ____

____

I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above.

Signature of Parent/Guardian _________________________________Date:_____________

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Camp Wyoming Health Form

To be completed by HEALTH CARE PROVIDER

Camper Name:____

Allergies:____

Reactions:____

Please give date of last immunization for:

________TD (tetanus/diphtheria)
________Tetanus
________Polio
________DTP
________Rubella
________Measles or Rubeola
________Haemophitus influenza B
________Hepatitis B
________Vancella Zoster
________TB Mantoux Test/Results:______

(Must have current TD prior to camp)

Past Medical History-(Include all surgical procedures)______________________________

____

____

Physical Exam:

Height:_______Weight:________B/P:_________P:___________R:________Temp:_________

	X if Normal	If Abnormal, Please Specify
HEENT	__________	______________________________
Cardiovascular	__________	______________________________
Respiratory	__________	______________________________
GI	__________	______________________________
GU	__________	______________________________
Neurological	__________	______________________________
Skin	__________	______________________________

Additional Information:____

____

The above named camper has had a health examination within the past 24 months.

Signature of Health Care Provider:______________________________Date:____________