



Camp Colorado 2011 Health Statement

Must Be Completed and Submitted to the Camp Director 3 Weeks Prior to Camp

This statement of health history is to be completed by a Physician or Nurse Practitioner within **24 months of camp**. Last year's statement or current school statement are acceptable. Failure to bring this record to camp will require that the camper be checked by the camp's physician at the parents' expense.

Camper's Name:	Age:	Birth date:
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Date of last visit to Physician or examination within **24 months** of camp:

This child/youth is planning to attend a week-long camp away from his/her home and some distance from care. The camp will have a health supervisor who has at least completed an advanced first aid course. Your response to all these questions will help to care for the child/youth. **Use back of form for additional information.**

Past history of serious lacerations, injuries or illnesses:

Any known allergies (e.g. Penicillin):

Medication now being used by child or special dietary requirement:

Attach an Official Certificate of Immunization or Complete the Following:

Vaccine	Month/Year Given	Vaccine	Month/Year Given
Diphtheria-Tetanus-Rubella		Rubella	
Tetanus-Diphtheria (TD)		Mumps	
Polio		Other (Specify)	
Measles (Hard, Red)		Other (Specify)	

I have examined this camper and found him/her to be in satisfactory physical condition and capable of active participation in a regular camp program except as follows:

Printed Name of Physician or Nurse Practitioner:	Date:
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Signature of Physician or Nurse Practitioner:

Physician Address/Phone:

Authorization for Emergency Medical Care –Health Insurance Information -Parents Complete

I hereby give my permission to Camp Colorado officials to call a doctor or emergency medical service and for the doctor, hospital or medical service to provide emergency medical or surgical care for my child, _____, (first and last name) should an emergency arise. It is understood that Camp Colorado officials will make a conscientious effort to locate the emergency contacts listed on the camp registration form before any action is undertaken. If it is not possible to locate emergency contacts listed, I/We accept the expense of emergency medical or surgical treatment (to the extent that it is not covered by my child's health care insurance, or the limited camp provided insurance).

Health Insurance Provider: _____ Phone Number: _____

Health Insurance Policy Number: _____

Parent's or Guardian's Signature: _____ **Date:** _____

Attach Copy of Child's/Youth's Health Insurance Provider Card/Certificate (front & back)