

Colorado Watersports Camper Health Form

Name _____ Social Security # _____

Parent or Guardian _____ Birth Date _____ Age _____ Sex _____

Home Address _____ Phone _____

E-Mail Address _____ Cell # (M:) _____ (F:) _____

Mother's Work Address _____ Phone _____

Father's Work Address _____ Phone _____

Second Emergency Contact Address _____ Phone _____

Third Emergency Contact Address _____ Phone _____

HEALTH HISTORY: Give approximate dates for each of the following, if applicable.

Ear Infections _____ Psychiatric _____

Heart Defect/Disease _____ Mononucleosis _____

Seizures _____ Diabetes _____

Bleeding Disorders _____ Chicken Pox _____

Hypertension _____ German Measles _____

HIV (Optional) _____ Mumps _____

Allergies: Hay Fever _____ Poison Ivy _____ Insect Stings _____ Penicillin _____ Other Drugs _____ Asthma _____

If Camper has ever required psychiatric counseling or hospitalization, please explain:

Please list any operations or serious injuries with dates: _____

Please identify any disability or chronic recurring illness: _____

List all current medications: _____

- **All medications must be properly identified and sent with instructions. Prescriptions must be in their original container with the prescription number, instructions, and the Doctor's name.** (Medications will be dispensed as prescribed, by the camp First Aid Director)

If Camper has ever required psychiatric counseling or hospitalization, please explain:

Please list any operations or serious injuries with dates: _____

Please identify any disability or chronic recurring illness: _____

List all current medications: _____

This health history is correct so far as I know, and the person listed above has permission to engage in all camp activities except as noted. I hereby give permission to the camp: 1. To provide ongoing first aid care. 2. To select medical personnel for the person listed above. 3. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injections and/or anesthesia and/or surgery for the person named above. This form may be photocopied for use out of camp. There are no undisclosed conditions that might affect this person's participation in the camp program.

Signature of parent or guardian of child: _____ **Date:** _____

I understand and agree to follow doctor's orders and abide by the restrictions placed on my camp activities.

Signature of camper: _____ **Date:** _____