Camp Maxwelton – Camp Lachlan

Health Medical Record

To Be Completed by Parents (please print or type)

Camper's Full Name _____Birth Date_____

Social Security # _____Home Phone _____Cell Phone _____

Parent's Name _____Business Phone_____

Address _____ Emergency Phone_____

_____

Does Camper wear braces, retainer, headgear, or other orthodontic wear? _____ If so, please include name and telephone number of orthodontist. _____ Phone _____

Does camper wear glasses or contact lenses? _____

Suggestions from Parents: _____

_____

_____

Important: Please notify camp if camper is exposed to any communicable disease during the three weeks prior to arriving at camp.

Parents Authorization:

I hereby give permission to the physician selected by the Camp Director to order x-rays, routine tests and treatment for my child. In the event I cannot be reached in an emergency, I 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 my child. I understand that should my child have to be hospitalized, all hospital bills and related doctors will be sent to me or to my family medical insurance carrier for payment.

Please include a photocopy of the front and back of your insurance card

Date_____ **Parent's Signature**_____

Medical Insurance Carrier_____

Policy Number_____

To Be Completed by Family Physician (please print or type)

Are Immunizations up to date? _____ Yes ____ No_ If "No" what needs to be monitored? _____

Date of last Tetanus Shot _____

Allergies (i.e. food, insect bites, poison ivy, etc)._____ ( ) No Allergies

How serious are allergies? _____ What treatments are administered for allergies? _____

Current medications __________

Medications brought to camp: Prescription: _____ OTC_____

Special instructions for medications to be administered at camp: _____

_____

_____

Are there any physical limitations we should be aware of? Please describe: _____

_____ has been examined by me and has been found fit to take active part in camp activities.

(name of Camper)

Date_____ _____

Signature of Physician

Physician's Name_____

Address_____

_____ Phone_____

Please return form to: Camp Maxwelton for Boys or Camp Lachlan for Girls

1629 Walkers Creek Road

Rockbridge Baths, VA 24473

FAX: 540.348.5757

PHONE: 540.348.5706

540.348.1090