

Longview Ranch Staff Health Record

Name _____ Age _____ Sex _____ Birth date _____
Address _____ City _____ State _____ Zip _____
Parent/Guardian if less than 18 _____
Day Phone _____ Home Phone _____
In case of emergency
notify _____ Relationship _____
(other than parent)
Home Phone _____ Day Phone _____

Health Information:

Are you subject to:

Diabetes Frequent colds Asthma Bronchitis
 Nosebleed Abscessed ears Fainting Bee Sting Allergy
 Earache Stomach upsets Sore throat Poison Ivy/Oak/Sumac
 Headache Sleepwalking Sinusitis Other

Please list any allergies
to foods or meds

Reaction

Degree
Severe to mild

1. _____
2. _____
3. _____

Medications: All medications other than those needed on an immediate basis will be kept in the possession of the camp nurse. Please bring all medications in their original container (prescription bottle). Please list all meds currently being used.

MEDICATION	DOSE	TIMES A DAY
1. _____		
2. _____		

To meet Tennessee Department of Public Health standards the following immunizations are required and must be current: Last Tetanus immunization _____ (booster every 10 years after initial immunization)
Polio _____ (at least 4 shots by kindergarten)

Please provide us with any other health information that would be helpful:

EMERGENCY CARE AUTHORIZATION: This health information and history is correct so far as I know. In case of an emergency, I understand that every effort will be made to contact parents or guardians of campers. In the event that I cannot be reached or if the urgency of circumstances makes it necessary, I hereby give permission to the physician selected by the camp director or his designee to hospitalize, secure proper treatment for and to order injections, anesthesia or surgery for the above named child.

Signature of Parent/Guardian: _____ Date: _____

Insurance Company: _____ Policy# _____

Physician's name: _____ Phone _____