



Camp Joy Medical Form

INSTRUCTIONS: Please read and complete this form carefully. **PLEASE PRINT**

PARTICIPANT'S LAST NAME: _____ **FIRST:** _____
Circle One: Male / Female **Circle One:** Chaperone / Participant **Participant's Birth Date:** / / **Age:** _____
Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Phone (____): _____
Primary Contact: _____ **Relationship:** (Parent / Guardian / Spouse / Other): _____
Primary Contact #'s: Home: (____) _____ Work: (____) _____ Other: (____) _____

IF PRIMARY CONTACT IS NOT AVAILABLE - IN AN EMERGENCY NOTIFY: (List 2 contacts at 2 different addresses)

1. Name: _____ **Relationship:** _____ **Address:** _____
City: _____ **State:** _____ **ZIP:** _____
Home # (____): _____ **Work # (____):** _____
2. Name: _____ **Relationship:** _____ **Address:** _____
City: _____ **State:** _____ **ZIP:** _____
Home # (____): _____ **Work # (____):** _____

PHYSICIAN & INSURANCE INFORMATION

Medical/Hospital Plan: _____ **Policy or Group #:** _____
Policyholders First & Last Name: _____ **Employer:** _____
Primary Physician's Name: _____ **Phone:(____):** _____
Family Dentist's Name: _____ **Phone:(____):** _____

IMMUNIZATIONS / RESTRICTITONS

Immunizations: DPT Date _____ Tetanus Date _____ **Have you had Chicken Pox? Circle:** Yes No
List any dietary restrictions: _____
List any activity restrictions: _____
List anything else, which would help us, better serve you: _____

MEDICAL CONDITIONS

- Tissue Transplant - Date of Transplant: _____
- Organ Transplant - Date of Transplant _____
- Type of organ transplanted _____
- Asthma (Does participant carry an inhaler?) _____
- Broken Bones _____
- Diabetes _____
- Ear Infections _____
- Headaches _____
- Heart Disease _____
- High Blood Pressure _____
- Infectious Hepatitis _____
- Psychiatric Care _____
- Pregnancy _____
- Fainting _____
- Convulsions / Seizures / Epilepsy _____
- Date of last Seizure: ____/____/____

ALLERGIES: Check all that apply

- Hay Fever _____
 - Insect Stings _____
 - Poison Ivy, other plants: _____
 - Peanuts, other foods: _____
 - Penicillin, Other drugs: _____
 - Latex _____
- Describe Allergic Reaction:** _____

Does participant carry an Epi-pen? _____
(If yes, please send Epi-pen with participant.)

Completed upon arrival by Staff:

Completed By: _____
Date: _____ **Cabin #** _____ **Session #** _____
 _____ Looks and feels well _____ Any skin conditions
 _____ Recent injuries _____ Head lice or scalp problem
 _____ Physical challenges/disabilities?
Additional information for the health care provider:

Please describe management of the above conditions or allergies.

PARENTAL ACKNOWLEDGMENT AND CONSENT

The health history is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted.
Authorization for treatment: I hereby give permission to the medical personnel selected by Joy Outdoor Education Center, LLC (JOEC) to provide routine health care, administer prescribed medications, and seek emergency medical treatment, including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes; I give permission to JOEC to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by JOEC to secure and administer treatment, including hospitalization, for the person named above. I give permission to the JOEC medical staff to assist my child with over-the-counter medication if needed.

Signature of Parent/Legal Guardian _____

Date _____