WASHINGTON PERFORMING ARTS
We make arts education happen

CONFIDENTIAL HEALTH FORM

Every camper needs a completed health form to participate in any summer camp programs. Please fill out this form as completely as possible. Thank you!

SECTION I – BASIC CONTACT INFORMATION Camper

Name_____ LAST FIRST MIDDLE

Birth Date_____/_____/_____ Age _____ Gender Male Female

Home Address_____ _____
STREET CITY STATE ZIP

Home Phone_____

Parent/Guardian #1 Name_____ Relationship:_____

Day Phone_____ Day Phone is Home Work Cell

Parent/Guardian #2 Name_____ Relationship:_____

Day Phone_____ Day Phone is Home Work Cell

Additional Emergency Contact_____Relationship_____ (In case we can't reach YOU)

Day Phone_____ Day Phone is Home Work Cell

Family Physician Name_____ Phone_____

SECTION II – INSURANCE INFORMATION

Is the camper covered by family medical/hospital insurance? Yes No

If yes, indicate Insurance Carrier_____ Group #_____

Policy #_____ Policy Holder's Name_____

SECTION III – MEDICATIONS

Will camper be taking medications while at camp? Yes No
(Medications include prescription, over-the-counter, vitamins, inhalers, etc.)
_____ I want the medication or medical devices self-administered. (Age 18 and above only.)
_____ I want the medication or medical device administered by the Health Services Staff. However, a limited amount of medication for life threatening conditions should be carried by my son/daughter/ward. (i.e. bee sting kits, inhalers)

Medication_____ Dosage_____ Take at what times_____

Reason for Taking_____

Prescribing Physician_____ Phone_____

Medication_____ Dosage_____ Take at what times_____

Reason for Taking_____

Prescribing Physician_____ Phone_____

SECTION IV – ALLERGIES

☐ Camper does not have any Allergies

Camper is allergic to ☐Hay Fever ☐ Poison Ivy/Oak ☐ Insect Stings ☐ Food ☐ Penicillin ☐ Other Drugs ☐ Other List allergy.

Describe reaction and treatment:

_____

_____

_____

SECTION VI – HEALTH HISTORY

Please know that we value your privacy. Health History information is available only to the camp health staff. The more information you provide, the better we can do our job. Thanks!

Has the camper have a history of or is prone to any of the following (Please check all that apply).

☐ Recent injury, illness or infectious disease

☐ Chronic or recurring illness

☐ Asthma

☐ Seizure Disorder or Convulsions

☐ Diabetes

☐ Frequent Headaches

☐Frequent Stomachaches

☐ Wears glasses or contacts

☐ Wears a Medic Alert ID

Please provide explanation for any checked items

_____

_____

_____

Date of Last Physical Exam (Recommended within 24 months of camp)_____

Physical Activities to be Limited or Restricted while at Camp

_____

_____

_____

SECTION VII – AUTHORIZATION

The information provided on this form is accurate to the best of my knowledge. I have indicated any special health conditions, including required medication and activity limitations which should be known to the camp staff and medical personnel. I am aware of and accept the risk inherent in the program activity. I give consent in advance for medical treatment at an appropriate facility in case of illness or injury. I authorize camp staff to administer basic first aid and obtain emergency medical services as necessary

Signature of Parent or Guardian X_____ Date_____