

## Health Information – Camp White Eagle, Inc.

NAME \_\_\_\_\_ SEX \_\_\_\_\_ AGE \_\_\_\_\_ COUNTY \_\_\_\_\_  
 BIRTHDATE \_\_\_\_\_ INSURANCE CO \_\_\_\_\_ POLICY # \_\_\_\_\_

To be completed and signed by parent or guardian. Fill in below any information you feel CWE (Camp White Eagle) personnel should know to ensure the safety and well being of your child. In case of an emergency this health statement may be our only source of accurate important information. Please be as accurate and complete as possible. Information is considered confidential. PLEASE PRINT.

PARENTS NAMES \_\_\_\_\_

HOME TELEPHONE \_\_\_\_\_ WORK (HIS) \_\_\_\_\_ (HER'S) \_\_\_\_\_

ONE OTHER EMERGENCY NAME & TELEPHONE \_\_\_\_\_

PARENTS ADDRESS \_\_\_\_\_

FAMILY DOCTOR \_\_\_\_\_ TELEPHONE \_\_\_\_\_

DOCTOR'S ADDRESS \_\_\_\_\_

Are there any restrictions that should be observed by the camper? \_\_\_\_\_

What medication is the camper taking currently? (name, amount, time) \_\_\_\_\_

Is the camper allergic to any medicines, foods, or other? \_\_\_\_\_

<u>YEAR OF ILLNESS:</u>	<u>HAS OR GETS FREQUENTLY:</u>	<u>IMMUNIZATIONS UP TO DATE</u>
_____ Appendicitis	_____ Diabetes	<u>FOR:</u>
_____ Chicken pox	_____ Epilepsy/Seizures	_____ Diphtheria
_____ German measles (3 day)	_____ Fainting	_____ Measles
_____ Measles	_____ Sinus trouble	_____ Polio
_____ Mumps	_____ Asthma/broncholltis	_____ Small Pox
_____ Rheumatic Fever	_____ Frequent colds	_____ Whooping cough
_____ Scarlet Fever	_____ Heart Disease	_____ Poison Ivy
_____ Sunstroke	_____ Constipation	_____ Tetanus
_____ Tonsillitis	_____ Discharge of ears	_____ (Date of last tetanus booster)
_____ Other	_____ Hay Fever	_____ Other
	_____ Sleep walker	
	_____ Other	

As parent/guardian, I delegate all matters of discipline and emergencies to CWE authorities. I understand that if a serious injury or illness develops, medical or hospital care will be given. I further understand that in case of serious injury or illness I will be notified. However, if it is impossible to contact me, I give permission for emergency treatment, x-ray, or surgery as recommended by the attending physician. We also will allow CWE staff to dispense non-aspirin pain reliever and ointment as necessary.

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

### Health record while at camp

Date	Symptoms	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____