Health Card # : ______________________ Week: _____ Cabin: ___________________

DORION BIBLE CAMP HEALTH FORM

Name: ______________________________ Birthdate:________________Age: ______
Address: ____________________________ City: _____________ Postal Code: ______
Parent or Guardian: __________________________________Phone #:______________
In case of an emergency contact: _______________________ Phone #: ____________
(their relationship to you) _______________________
Family Doctor: ___________________________________ Phone #: _______________
Hospital preferred: ____

HEALTH HISTORY (indicate year if possible):

_____ chicken pox
_____ measles
_____ mumps
_____ whooping cough
_____ rheumatic disease
_____ bronchitis

Please Indicate Medication

_____ diabetes ____________________ meds
_____ seizures ____________________ meds
_____ asthma _____________________ meds
_____ kidney problem ______________ meds

INDICATE THE FREQUENCY OF THE FOLLOWING:

_____ sleep walking
_____ bed wetting
_____ constipation
_____ headaches
_____ fainting spells
_____ ear aches and infections
_____ sore throats
_____ sinus trouble
_____ colds
_____ rashes

ARE THERE ANY OTHER HEALTH COMPLICATIONS WE SHOULD KNOW ABOUT?____

ALLERGIES AND REACTIONS:

Penicillin or other drugs: ____
Insect bites: ____
Food or diet restrictions: ____
Is immunization up to date? ____
List any activities which should be restricted: __________________________________

ON THE BACK PLEASE LIST ANY REGULAR MEDICATION NEEDED: NAME, DOSAGE, AND FREQUENCY.

A doctor's signature is NOT required.

Date of last medical exam: ___________ Parent Signature:__________________________