

CYO Camp Adult Health Form (18 and over)

Personal History

Name:	Home Phone:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address:	Work Phone:	Date of Birth:
City, State, Zip:	Cell Phone and/or Pager:	Height: Weight:

Emergency Contact Information

Name:	Relationship:	Home Phone:	Work Phone:
Name:	Relationship:	Home Phone:	Work Phone:

Insurance Information

Please include a copy of your insurance card.

CYO Camp does NOT carry health/accident insurance for campers, schools and conference camping participants.

Primary Policy Holder:	Insurance Company:	Policy Number:
Secondary Insurance Holder:	Insurance Company:	Policy Number:
Physician's Name:	Physician's Phone Number:	Date of Last Visit:

Medication Information

To the best of your knowledge, are you free of any communicable diseases?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, please explain:
Are you allergic to any medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain:
Are you allergic to anything else? (i.e. foods, animals, environmental allergies, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain:
Are you under the care of a physician now?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain:
List any medications you are presently taking:		
Date of last Tetanus Booster: ____/____/____	Have you completed Hepatitis B Immunizations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last T. B. test: ____/____/____	Result of T.B. test: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	
Do you have any physical or mental limitations, which could interfere with your activities at camp?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain:

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Communicable Disease History

Please check any that apply:

Chicken Pox
 Hepatitis
 Measles, German

Measles, Red
 Mumps
 Mononucleosis

Tuberculosis
 Whooping Cough
 Other (Specify)

Other Health Issues

Please check any that apply:

Asthma
 Bleeding Disorders
 Diabetes
 Ear Aches
 Eating Disorders
 Emotional Concerns

Frequent Colds
 Headaches
 Hearing Difficulties
 Heart Condition
 Hypertension
 Migraine Headaches

Seizures
 Sight Difficulties
 Sinus Infections
 Skin Conditions
 Urinary Tract
 Other _____

Explanation of Treatment of Above: _____

State recent operations, illnesses and/or injuries: _____

Authorization

(This section must be signed and is required under California State laws, unless there is religious objection.) "This Camp Health Information is correct so far as I know and I am able to engage in all camp activities, except as specified. I hereby give my permission to _____ to secure emergency medical and surgical treatment and to provide routine medical care for me while at camp."

Signature

Date