Youth Health History

Camper's Name:	Birth Date:
Parent or Legal Guardian:	Height:
Address:	Weight:
City: State: Zip:	Sex: F or M
Telephone (Day): (Night):	School:

Date of Last Tetanus Booster:	
Allergies:	
Chronic or Recurring Illnesses:	
Operations or Serious Injuries:	
Health Concerns or Activities to Be Restricted:	
Current Medications*:	
Physician's Name:	Phone Number:
Health Insurance Carrier:	Policy Number:

*All medications must be brought to camp in the original prescription container which bears the child's name, physician's name, type of medication, and prescribed dose.

AUTHORIZATION TO SECURE PROPER MEDICAL TREATMENT

I am the parent or legal guardian of this child. I certify that this health history is correct so far as I know and that this child may participate in all activities except those noted above.

In the event that I cannot authorize medical treatment in any emergency, I hereby give permission to the physician selected by the camp director (or other authorized representative of the Wyman Center) to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for this child.

Signature of Parent Or Legal Guardian: ______________________ **Date:** __________