# HEALTH HISTORY FORM

## CAMP COSBY

**A Tradition of Excellence Since 1922**

Phone: (800) 852-6729/(256) 268-2007
Fax: (256) 268-2003
Email: Info@campcosby.org

Participant Name_____ D.O.B.____/____/____ Age_____ Sex_____
LAST FIRST M.I.

Parent/Guardian Name_____ Daytime Phone_(____)_____-_____
(IF PARTICIPANT IS UNDER 18)

Home Address_____ Night-time Phone(____)_____-_____
STREET CITY,STATE ZIP

### EMERGENCY CONTACT

**If, in the event of an emergency, the parent/guardian cannot be contacted, please contact the following:**

Name_____ Relationship_____ Daytime Phone(____)_____-_____

Address_____ Nighttime Phone(____)_____-_____

### HEALTH HISTORY

**(To be filled out completely by participant OR parent/guardian if under 18)**

Please list any current medications being taken and explain their purpose_____

Please list and explain any physical limitations that may prevent or limit your participation in Camp Cosby activities_____

Please list and explain any allergies_____

Please list and explain any illnesses or injuries Camp Cosby staff should be aware of (shoulder dislocations, knee surgeries, diabetes, asthma, etc.)_____

### PERMISSION TO TREAT/ADMINISTER MEDICATIONS

By signing below, I hereby give permission (standing orders) to Camp Cosby and its staff to treat me, or my child, for injuries as needed. I understand that all Camp Cosby staff are certified, as a minimum, in First Aid and C.P.R. In the unlikely event of an emergency, I give permission (standing orders) to Camp Cosby, it's staff, and local medical personnel to transport my child to a medical facility if necessary (hospital, clinic, etc.). Furthermore, I give permission (standing orders) to Camp Cosby and it's staff to dispense/administer medications brought to camp by parent/guardian for my child or prescribed by the camp's physician while in attendance. Any non-prescription medications that you authorize use of need to be listed below.

Authorized non-prescription medications (aspirin, acetaminophen, ibuprofen, antihistamines, etc.)_____

Parent/Guardian Printed Name_____

Parent/Guardian Signature_____ Date_____

### INSURANCE INFORMATION

Is participant covered by medical/hospital insurance?_____ If so, list policy/group number_____
Carrier Name_____ Carrier Address_____
Name of Insured_____ Relationship to participant_____
Parent/Guardian Signature_____ Date_____