



KRISLUND CAMP & CONFERENCE CENTER
 189 Krislund Dr., P.O.Box 116 Madisonburg, PA. 16852
 Phone: (814) 422-8878 Fax: (814) 422-8552

Name: _____

CAMP HEALTH FORM

Krislund requires all campers to have had a physical by a licensed health care provider within the past two years. Physical forms of last year's campers are on file and acceptable if the examination date was within the two-year limit. A physical examination form is provided, or a photocopy of another form with a licensed provider's signature is acceptable (i.e., sports physical). The **Camp Health Form** and the **Camp Physical Form** must be provided at time of check-in.

Camper's name: _____ **DOB** _____ **Gender** _____

Parent or Guardian: _____ **Phone:** (____) _____

Home Address: _____

Business Address: _____

E-mail : _____ **Mobile Phone** (____) _____

Second Parent/Guardian/Emergency contact: _____

Relationship: _____ **Phone** (____) _____

Other emergency contact: _____

Relationship: _____ **Phone** (____) _____

IMPORTANT - THIS BOX MUST BE COMPLETED FOR ATTENDANCE

This health history is correct so far as I know, and may be photocopied for trips out of camp. It is understood that the summer activities, described in the brochure, include managed risk activities (i.e., caving, hiking, low ropes, wall climbing, and high ropes). The person named above has permission to engage in all prescribed camp activities except as noted.

EMERGENCY AUTHORIZATION: I hereby give permission to the medical personnel selected by the Camp Administrator to: provide routine and emergency health care; administer medications; order X-rays, routine tests, treatment; release any records necessary for insurance purposes; and provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the Camp's health care manager to secure and administer necessary treatment, including hospitalization, for the person named above.

SIGNATURE of parent/guardian : _____

Date: _____

Medical Insurance Information

Insurance carrier: _____

Policy Holder: _____ **DOB:** _____

Policy or group #: _____

Camper's coverage/ID #: _____

Unit: _____

Year: _____

Date of last tetanus vaccination: _____

The following items or similar brand equivalents are routinely used for first aid and other minor ailments. If you do **NOT** want your child to receive any one of these, please put "NO" in the space next to the item.

We do not administer aspirin tablets.

- | | |
|---|--|
| <input type="checkbox"/> Loratadine (antihistamine) | <input type="checkbox"/> Hydrogen Peroxide |
| <input type="checkbox"/> Pseudoephedrine | <input type="checkbox"/> Rubbing Alcohol |
| <input type="checkbox"/> Adhesive Tape | <input type="checkbox"/> Antibiotic ointment |
| <input type="checkbox"/> Hydrocortisone Cream/Cortaid | <input type="checkbox"/> Calamine Lotion |
| <input type="checkbox"/> Pepto Bismol | <input type="checkbox"/> Milk of Magnesia |
| <input type="checkbox"/> Benadryl Tablet | <input type="checkbox"/> Immodium |
| <input type="checkbox"/> Tums Antacid Tablets | <input type="checkbox"/> Ibuprofen |
| <input type="checkbox"/> Tylenol | |

Other suggestions or health related information for camp Health Care Manager, including activity restrictions:
