

2026 CAMP PALATINE

CAMPER'S PERSONAL HEALTH AND MEDICAL SUMMARY
Fax# 518-537-6001

To be filled out by Parent and Doctor

Please print in ink

IDENTIFICATION

Name _____ Date of Birth _____ Age _____ Sex _____

Name of parent or guardian _____ Telephone _____

Home address _____ City _____ State _____

Business address _____ City _____ State _____

If Person Above Is Not Available In The Event Of An Emergency, Notify:

Name _____ Relationship _____ Telephone _____

Name _____ Relationship _____ Telephone _____

Name of personal physician _____ Telephone _____

Personal Health/Accident Insurance carrier _____ Policy No. _____

In case of an emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery or injections of medication for my child.

Date _____ Signature of parent or guardian _____

Medical Information Past Or Present That We Should Be Concerned About: (please check)

Asthma Yes ___ No ___ Heart disease Yes ___ No ___ Leukemia Yes ___ No ___

Allergies Yes ___ No ___ Cancer Yes ___ No ___ High blood pressure Yes ___ No ___

Convulsions Yes ___ No ___ Diabetes Yes ___ No ___ Hemophilia Yes ___ No ___

Special Instructions to Us: _____

Allergies: Food Yes ___ No ___ Plants Yes ___ No ___

Medicine Yes ___ No ___ Insect Bites Yes ___ No ___

Explanations/Special Instructions to Us: _____

Any Reason To Restrict Full Activity Including, Long Hikes, Backpacking, Strenuous Physical Games? Yes ___ No ___

List Any Conditions Limiting Full Participation (Physical or Emotional) _____

(OVER)

MEDICINES AND IMMUNIZATIONS

Are You Sending Any Medicines With Your Child To Camp Palatine? Yes____ No____

Any Reason for Medicines to Be Taken On an Off Camp Trip? Yes____ No____

Any Special Equipment Such As Orthopedic or Handicap Devices, Glasses or Contacts, Dentures, Epi-Pen Etc.? Yes____ No____

Describe?

***Please attach immunization records to this form**

Any Additional Instructions to Our Staff:

Parent/Guardian Signature