COASTAL EMPIRE LACROSSE CAMPS
HEALTH HISTORY FORM

******PLEASE BRING THIS FORM WITH YOU TO CAMP******

(You cannot be admitted to camp without this completed form.)

Camper's Name_____ **Sex:**_____**Age:**_____**Ht.**_____**Wt:**_____

Address:_____**Phone#:**_____

HEALTH HISTORY

IF THE CAMPER SHOULD BE RESTRICTED FROM ANY ACTIVITY, PLEASE NOTE:

_____

_____

If the camper will be taking medication during camp, please indicate name of drug and dosage:

_____

Please identify any medical condition or history which would require special attention:

_____

Has the camper had any of the following? (Please circle for YES): Asthma, Chicken Pox, Diabetes, German Measles, High Blood Pressure, Measles, Mumps, Pneumonia

ALLERGIES (yes/no)	*DRUG REACTIONS* (yes/no)
Hay Fever_____	Sulpha_____
Asthma_____	Penicillin_____
Eczema_____	Antibiotics (type)_____
Insect Stings_____	_____
Other (type)_____	Other_____

Physician's Name_____ **Telephone** _____

Parent(s) Names: _____

Home Phone Number: (____**)**_____**Work Number: (**_____**)**_____

My Phone Number while my child is at camp: (if different from above): (_____**)**_____

Person to contact in the event I cannot be reached:_____

Phone number of emergency contact person: (___**)**_____