



# Camp Ewalu Summer

# Health History

# 2019

Mail to: Camp Ewalu, 37776 Alpha Avenue, Strawberry Point, IA 52076 | Office Hours: M-F, 8 am-4:30 pm  
Phone: 563-933-4700 | Website: [www.ewalu.org](http://www.ewalu.org) | E-mail: [camp@ewalu.org](mailto:camp@ewalu.org) or Registrar: [office@ewalu.org](mailto:office@ewalu.org)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Male  Female

Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Billing Address: \_\_\_\_\_

(If different from child's address)

### Parent / Guardian

Parent/Guardian 1: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

Parent/Guardian 2: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

In case of Emergency, contact (other than parents): Name(s) \_\_\_\_\_

Phone(s): \_\_\_\_\_ Relationship \_\_\_\_\_

Name of Program: \_\_\_\_\_ Program Date: \_\_\_\_\_

### **Health History & Insurance:** *Please continue on reverse side or attach pages if needed*

1. Date of Last Health Examination: \_\_\_\_\_ (must be within 12 months)

2. Immunizations: DPT: Y / N Measles-Rubella: Y / N Polio: Y / N Hepatitis B: Y / N Varicella: Y / N

Date of Tetanus Shot: \_\_\_\_\_

3. Skin Diseases: Y / N, If Yes, please explain \_\_\_\_\_

4. Allergies (food, drugs, hay fever, insects, etc.): Y / N If Yes, please explain \_\_\_\_\_

Medical Diet Needs: \_\_\_ Nut allergy, \_\_\_ Gluten free, \_\_\_ Dairy free, \_\_\_ Vegetarian, Other: \_\_\_\_\_

5. Medications & Treatments: List all current or ongoing treatments or medications, including dosage:

6. List any illness, chronic conditions, physical conditions or psychological conditions the camper has that requires restrictions on Camp participation (including past medical history):

7. Physician's Name \_\_\_\_\_ Office Phone \_\_\_\_\_

8. Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

To the best of my knowledge, all health information for the person described herein is correct. I authorize the medical personnel or staff selected by the camp director to secure any medical or emergency treatment deemed necessary for the person named above. Parents will be notified in case of emergency. In the event of an accident, injury, or illness, the insurance of the camper's parent or guardian is primary. I certify that the applicant has had a physical examination within the 12 month period prior to arrival at camp.

Signature of Parent/Guardian, or adult camper (if over 18) \_\_\_\_\_

Date \_\_\_\_\_