

**Natural Horse Savvy
Camper Health Information and Consent to Treat**

1

Child's Name _____

Last MI First

Date of Birth (MM/DD/YYYY) _____ Age at time of camp _____

Address _____

Street Apt City State Zip

1 Parent Name (custodial parent or guardian) _____

Home () _____ Work () _____ Cell () _____

2 Parent Name _____

Home () _____ Work () _____ Cell () _____

Where can you be reached **during camp**? _____
If you plan to be out of town, please attach your itinerary and contact numbers.

Emergency/Alternate Contact

In case we cannot reach you, list at least two relatives or friends who you can authorize to act on your behalf, including health care decisions, **and** to whom your child can be released during the session for whatever reason:

Name _____ Phone () _____

Name _____ Phone () _____

Health Care Providers

Name of Camper's Physician _____ Phone () _____

Name of Camper's Dentist _____ Phone () _____

Medical Insurance Information:

This camper is covered by family medical/hospital insurance **Yes** **No**
Include a copy of your insurance card if appropriate; copy both sides so the information is able to be read.

Insurance Company _____ Policy Number _____

Subscriber _____ Insurance Company Phone Number _____

Parent/Guardian Authorization and Consent to Treat:

The enclosed health history is correct and complete as far as I know. I have read the information relating to the event. I understand the information and agree to abide by the terms. As parent/guardian having legal custody of the camper named, who is voluntarily enrolled as a participant in the Natural Horse Savvy day camp program, I understand that camping programs involve inherent risk and possible injury because of the nature of the activity, even when conducted in a safe manner. I give permission for him/her to attend camp and participate in all phases of the program. I understand that a statement of his/her good health is required before he/she may attend. I authorize all medical, surgical, diagnostic and hospital care or procedures which may be performed or prescribed for my child by a licensed physician or hospital, when efforts to contact me are unsuccessful and when deemed immediately necessary or advisable by the physician to safeguard my child's health. I waive my right of informed consent to such treatment.

Signature of Custodial Parent/Guardian Date Relationship to Camper

Complete Health History on reverse side

Camper Name _____
Last _____ MI _____ First _____
Session(s) Attending _____

Natural Horse Savvy Camper Health Information and Consent to Treat

Health History:

Date of last health examination: _____

Were any complicating medical problems noted in last health examination? _____

Is participant currently under the care of a physician or psychologist? _____

Since the last health exam, has participant had:

- | | |
|--|---|
| <input type="checkbox"/> a serious injury requiring medical attention? | <input type="checkbox"/> an illness lasting more than five days? |
| <input type="checkbox"/> any prescribed or over-the-counter medication ? | <input type="checkbox"/> a surgical operation or fracture? |
| <input type="checkbox"/> treatment in a hospital or emergency room | <input type="checkbox"/> any restrictions concerning physical activities? |
| <input type="checkbox"/> any exposure to a contagious disease? | |

Please explain any "checked" answers to the questions. Include dates: _____

Please explain care or treatment of any items checked above. Indicate any information useful to camp staff in relation to these health conditions. Attach a separate sheet if necessary. _____

Immunization History:

Are the required school immunizations up to date? Yes No Date of last Tetanus shot _____

Hepatitis A Yes No Chicken Pox Disease Yes No Chicken Pox Vaccine Yes No

Other (mo/year) Disease: _____

Is there a medical or dietary regimen to be followed? _____

Explain any restrictions to activities; what cannot be done, what adaptations or limitations are necessary? _____

Any emotional or behavioral problems? _____

Chronic Illnesses:

- Heart disease
- Asthma
- Rheumatic fever
- Sickle cell anemia
- Diabetes
- Tuberculosis
- Epilepsy/seizures

Diseases:

- Eating disorder
- Mononucleosis
- Emotional disturbances
- Recent infections: _____
- Other (specify): _____

Other Health Conditions: (check all that apply)

- Frequent colds
- Stomach upsets
- Constipation/diarrhea
- Menstrual cramps
- Motion sickness
- Wears glasses
- Fainting
- Kidney trouble
- Hearing impairment
- Frequent sore throats
- Frequent ear infections
- Nosebleeds
- Wears contact lenses
- Other (specify): _____

Allergies:

- No known allergies
- This camper is allergic to (please list allergy and reactions-use additional sheets if necessary):

Medication Allergies	Reaction or Symptom	Management or Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

Food Allergies

_____	_____	_____
_____	_____	_____
_____	_____	_____

Other Allergies (include Insect stings, hay fever, asthma, animal dander, latex, etc.)

_____	_____	_____
_____	_____	_____
_____	_____	_____