Camp Shalom
Health History and Pick Up Authorization

Child's Last Name	First Name	MI	Home Phone #
Home Address		City/Zip Code	
Mother's Name	Work Phone	Cell Phone	Email Address
Father's Name	Work Phone	Cell Phone	Email Address

Please list at least two people to call (other than parent's) in an emergency:

Name	Relationship to Child	Home #	Cell #
Name	Relationship to Child	Home #	Cell #
Name	Relationship to Child	Home #	Cell #

Important – Must be complete for attendance.

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed medications and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization for the person named above. The completed form may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper/staffer _____
Printed name _____ Date _____

I also understand and agree to abide by any restrictions placed on me by my participation in camp activities.
Signature of minor or adult camper/staffer _____ Date _____
*If for religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

ALLERGIES (list all known) Describe reactions and management of the reaction.
Medication allergies (list all)

_____ _____
_____ _____

Food Allergies (list all)

_____ _____
_____ _____

Other Allergies (list all) including insect stings, fever, asthma, animal dander, etc.

_____ _____
_____ _____

MEDICATIONS BEING TAKEN

Please list ALL Medications (including over the counter or nonprescription drugs) taken routinely. Bring enough medications to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug) the name of the medications, the dosage and the frequency of administration.

____ This person takes NO medications on a routine basis. OR ___ this person takes medications as follows:

Med #1 _____ Dosage _____ Specific time to be taken _____
Reason for taking _____

Med #2 _____ Dosage _____ Specific time to be taken _____
Reason for taking _____

Attach additional pages for more medications. Identify any medications taken during the school year that camper does not take during the summer: _____

RESTRICTIONS: (the following restrictions apply to this individual)
Does not eat: _____
List any restrictions to activities due to the above food allergies: _____

Use this space to provide any additional information about the participant's behavior and physical, Emotional or mental health about which the camp should be aware:

_____

_____

Name of family physician: _____ Phone: _____
Address: _____

Name of family dentist: _____ Phone: _____
Address: _____

THE FOLLOWING PEOPLE HAVE PERMISSION TO PICK UP MY CHILD.
Please print the names of everyone allowed to pick up your child, including parent's names.

	Name	**Home**	**Cell**
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____

_____ _____ _____
Signature of Parent Relationship to Child Date

PASSWORD: _____ (Please print clearly)