Medical Information

Indicate medication(s) which is/are taken on a regular basis.
Participant should bring an adequate supply of their medication(s) with them.
It is MANDATORY that all medications held by a participant be disclosed on this form.
If desired, the Head counselor will hold and dispense medication(s) to the participant.
It is NOT mandatory that the Head Counselor maintains possession and dispenses medication(s).

Participant Name _____ Date of Birth _____

Phone # _____ Email Address _____

MEDICATIONS

_____
Name of Medication Dosage Prescribing Physician

_____
Name of Medication Dosage Prescribing Physician

_____
Name of Medication Dosage Prescribing Physician

MEDICAL HISTORY

Allergies	Yes	No	**Heart Disease**	Yes	No
Convulsions	Yes	No	**Phobias or Fears**	Yes	No
Diabetes	Yes	No	**Past Injuries/Illnesses**	Yes	No
Disabilities	Yes	No	**Past Operations**	Yes	No
Epilepsy/Seizure Disorder	Yes	No	**Other**	Yes	No

If you answered "yes" to any of the above conditions, please explain in detail. Use a separate page if necessary.

_____

_____

Please advise of any special instructions, side effects or emergency procedures.

_____

_____

Date of last tetanus booster:

Parent/Guardian Signature: _____ Date _____