mountain friends camp

Medical History FORM 1

To <u>Adult Participant:</u> Please follow the instructions below. Attach additional information if needed.

1. **Complete this form (FORM 1) and make a copy.**
2. **Send original, signed form to camp by June 1.**
3. **Complete the top section of FORM 2 (Health-care Recommendations) and provide copy of FORM 1 with FORM 2 to your health-care provider for review and completion. Only a licensed physician or physician's assistant is eligible.**
4. **After it has been completed and signed by your health-care provider, return FORM 2 to camp by June 1.**

Participant Information

Name_____ Gender _____

D.O.B___/___/__ Age at Camp_____ Height_____ Weight_____

Physician_____ City, State_____

Person to notify in case of illness or injury

Name_____ Relationship_____

Address_____

City_____ State, ZIP_____

Tel (home) _____ (cell)_____

Insurance

Are you covered by hospitalization and medical care insurance? Yes____ No_____

Name of Insurance Company_____

Policy #_____ Telephone #_____

Medical Information

If you have any of the following health concerns, please check below AND describe in detail on back of form, use additional pages if necessary:

Recurrent/Chronic Illness? ( ) Illness lasting more than one week? ( ) Hospitalizations? ( )
Surgery? ( ) Missing organs? ( ) Allergy to medications? ( )
Allergies to foods? ( ) Allergies to other substances? ( ) Chest pain with exercise? ( )
Dietary Restrictions?_____
Asthma? ( ) Uses inhaler? _____ Allergic to bees? ( ) Uses epipen? ( )
Dizziness, fainting, frequent headaches, migraines? Convulsions? ( ) Concussion or unconsciousness? ( )
Heat exhaustion, heat stroke or other problems in heat? ( ) Glasses or contacts? ( )
Is there a history of broken bones or joint or muscle injury? ( ) Skin conditions or sensitivity ( )
Dizziness or fainting with exercise? ( ) Heart or blood pressure problems? ( )
Wears dental bridges, braces, or retainers? ( ) Hearing loss? ( )
History of autism, CP or other developmental differences ( ) Any eating or nutritional disorders? ( )
History of bulimia, anorexia, depression, severe anxiety or other mental or emotional problems ( )
What is the date of last tetanus shot? _____ Under the care of a physician? ( )
Any Medications? ( ) Please indicate name, amount and condition for use for all medication_____

2455 Race Street
Denver, CO 80205
Phone: (435) 554-1132
IMYM.org/mtnfrcamp
Director@MountainFriendsCamp.org
www.MountainFriendsCamp.org

mountain friends camp

Medical History Form 2 continued

Participant Information
Name_____ D.O.B___/___/__

Medical Information
If you have any health concerns that we should be aware of, please check above and describe in detail, use additional pages if necessary:

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