



TRAIL BLAZER CAMPS HEALTH RECORD

TRIP 1 2 3 4

CAMPER FIRST NAME _____ LAST NAME _____

NICKNAME _____ DATE OF BIRTH _____ PRESENT AGE _____

PARENT/GUARDIAN FIRST NAME _____ LAST NAME _____

RELATIONSHIP TO CHILD _____ SOCIAL SECURITY # _____

HOME TELEPHONE # _____ WORK TELEPHONE # _____ EXT _____

CELL # _____ EMAIL _____ FAX # _____

ADDRESS _____ APT # _____

CITY _____ STATE _____ ZIP CODE _____

EMERGENCY CONTACT (NOT PARENT) FIRST NAME _____ LAST NAME _____

RELATIONSHIP TO CHILD _____ HOME TELEPHONE # _____

WORK TELEPHONE # _____ EXT _____ CELL # _____

MEDICAL	DATE	CHILD IS SUBJECT TO	CHECK	ALLERGIES	CHECK	IMMUNIZATIONS	LAST DATE
ADD OR ADHD		BRONCHITIS		PENICILLIN		DPT/TETANUS (Diphtheria, pertussis, tetanus)	
DIABETES		ASTHMA		HAY FEVER		POLIO	
CHICKEN POX		EAR INFECTION		BEE STING		MMR (Measles, mumps, rubella)	
MUMPS		CONVULSIONS/ SEIZURES		POISON IVY		HEP (Hepatitis B)	
RHEUMATIC FEVER		BED WETTING		DRUGS		TUBERCULIN	
TUBERCULOSIS		HEART TROUBLE		FOOD (WHICH TYPE)		HIB (Haemophilus b)	
OTHER		SICKLE CELL		OTHER		VARIVAX	
		OTHER				MENINGITIS	

ANY CHRONIC OR RECURRING ILLNESSES _____ OPERATIONS OR SERIOUS INJURIES _____

PRESCRIPTION MEDICATION TAKEN BY CHILD: _____

WHAT IS MEDICATION TAKEN FOR? _____

INSURANCE INFORMATION AND MEDICAL CARE PERMISSION

I HEREBY GIVE PERMISSION TO THE PHYSICIAN SELECTED BY TRAIL BLAZERS TO ORDER X-RAYS, ROUTINE TESTS AND TREATMENT FOR THE HEALTH OF MY CHILD. IN THE EVENT THAT I CANNOT BE REACHED IN AN EMERGENCY, I HEREBY GIVE PERMISSION TO THE PHYSICIAN SELECTED BY TRAIL BLAZERS TO HOSPITALIZE, SECURE PROPER TREATMENT FOR AND TO ORDER INJECTION AND/OR ANESTHESIA AND/OR SURGERY FOR MY CHILD AS NAMED HEREIN. I HEREBY GIVE PERMISSION FOR THE MEDICAL PERSONNEL SELECTED BY TRAIL BLAZERS TO ADMINISTER ANY NECESSARY MEDICATIONS TO MY CHILD.

I AGREE TO PAY VACAMAS PROGRAMS FOR YOUTH FOR ANY MEDICAL PRESCRIPTIONS OR TREATMENT ORDERED FOR MY CHILD IF THE DOCTOR/PHARMACY DOES NOT ACCEPT MY INSURANCE PLAN. I, THE UNDERSIGNED, GIVE PERMISSION TO ANY MEDICAL FACILITY TO BILL ME DIRECTLY TO MY HOME ADDRESS AND I THE UNDERSIGNED RELEASE VACAMAS OF ALL OBLIGATIONS, FINANCIAL OR OTHERWISE.

NAME OF PRIMARY INSURANCE PLAN _____

PRIMARY INSURED NAME ON INSURANCE CARD _____

IDENTIFICATION NUMBER _____ GROUP NUMBER _____

DATE _____ PARENT/GUARDIAN SIGNATURE _____