CAMP LONG-A-COMING 2009 MEDICAL QUESTIONNAIRE

Child_____ Home Phone (____) _____
Last First
Address_____

Name of Parent Guardian_____

In case my child becomes ill or injured at Camp I can be reached at:
Phone# _____ Cell#_____

If I cannot be reached please call:
Name_____ Phone#_____

Directions: Answer all questions by circling Yes or No

1.	Has been medically advised not to participate in any sports		Yes	No
2.	Is under a physician's care and the reason for such care		Yes	No
3.	Has experienced loss of consciousness after an injury		Yes	No
4.	Has experienced a fracture or dislocation		Yes	No
5.	Has undergone any surgery		Yes	No
6.	Takes any medication regularly, name of medication/reason		Yes	No
7.	Has allergies including hives, asthma or **reaction to bee stings**		Yes	No
8.	Has experienced frequent chest pains or palpitations		Yes	No
9.	Has a history of fainting with exercise		Yes	No
10.	Has a history of a family member having sudden death		Yes	No
11.	Has any hearing loss		Yes	No
12.	Has impaired vision	A. must wear glasses or contacts	Yes	No
		B. has loss or seriously impaired	Yes	No
13.	Has a history of the following:	Anemia	Yes	No
		Mononucleosis	Yes	No
		Hypertension	Yes	No
		Tuberculosis	Yes	No
		Diabetes	Yes	No
		Asthma	Yes	No

Further explanation of "Yes" answers to question: (use separate sheet if necessary)

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_____

Family Doctor_____Phone#_____

EXTREME EMERGENCY, If possible take my child to_____Hospital

_____
Signature of Parent or Guardian