Borough of Berlin
2010 Camp Long-A-Coming
MEDICAL QUESTIONNAIRE

Child's Name (Last name, First)_____

Address _____

Home Phone _____

Parent/Guardian Name _____

In case my child becomes ill or injured 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 a **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. completely 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

If any above answers are "Yes", please describe below. (Please use a separate sheet if necessary)

_____

_____

_____

Family Doctor _____ Phone _____

In the case of an EXTREME EMERGENCY, if possible, take my child to _____ hospital.

_____
Signature of Parent or Guardian