

C A M P E R H E A L T H & D O C T O R E X A M I N A T I O N F O R M

Child's Name (First & Last): _____ Age: ____ Date of Birth: _____

Parents/Legal Guardian(s): _____ Child Social Security Number _____

Phone () _____ Phone Type (circle one): home work cell

M E D I C A L I N S U R A N C E A N D I M M U N I Z A T I O N H I S T O R Y

Please include a copy of your child's medical insurance card.

Name of Insurance Company for Health and Accident: _____ Policy # _____

If child has a Medi-Cal Card, please give policy #: _____

Attached is a copy of my child's immunization record, including when the child received the shots. (A COPY of school records is acceptable, please *do not send original*).

My child has received the H1N1 Vaccination: (circle one) Yes No

H E A L T H H I S T O R Y

Indicate if child is currently or in the past had any of the items listed below. If yes, give approximate dates.

- _____ Frequent Ear Infections
- _____ Heart Defect/Disease
- _____ Convulsions
- _____ Diabetes
- _____ Bleeding/Clotting Disorders
- _____ Hypertension
- _____ Chicken Pox
- _____ Measles/German Measles (circle)
- _____ Mumps
- _____ Head Lice

Concern with Allergies (Please specify): _____

Chronic or recurring illness or medical condition: _____

Any specific activities to be encouraged or restricted from: _____

For GIRLS only... has your child menstruated? (Circle one) YES NO

P A R E N T A U T H O R I Z A T I O N

The Alisa Ann Ruch Burn Foundation (Foundation) REQUIRES that this form to be completely filled out, at the responsibility of the parent/guardian of this child. The Foundation reserves the right to not accept a child if this form is not returned to us prior to the beginning of camp. This information is gathered to assist us in identifying appropriate care.

This health history is correct so far as I know and the person herein described has permission to engage in all prescribed camp activities except as noted by me and the examining physician. I/We hereby give permission to the physician or other medical personnel selected by Wonder Valley Ranch and the Alisa Ann Ruch Burn Foundation to obtain and administer any surgical and medical treatment, or hospitalization needed in the case of an emergency for my child named above. I/We agree that Wonder Valley Ranch or their authorized agents may administer over-the-counter medications, or their generic equivalent, as deemed necessary such as but not limited to: Calamine lotion, Betadine, Milk of Magnesia, Pepto Bismol, Aspirin, Tylenol, Neosporin Ointment, Sun block, Sucretes, Sting ointment, Blistex and Visine.

Parent/ Guardian Signature _____

Date _____

*****MEDICAL EXAMINATION TO BE FILLED OUT BY PHYSICIAN ON BACKSIDE *****





CHAMP CAMP

1986 - 2010

Spanish Interpretation Available /

Si Necesita Ud. Puede Aplicar en Español -1 (888) 492-2876

******* TO BE FILLED OUT BY A LICENSED PHYSICIAN *******

This examination is for determining fitness and general health to engage in a variety of basic activities while at CHAMP CAMP
a summer camp for burn-injured children **Fax to: (415) 495 - 7224**

E X A M I N I A T I O N

Child's Name (First & Last): _____ Age: ____ Date of Birth: _____

Parents/Legal Guardian(s): _____

Child's Weight: _____ lbs Height: _____ Blood Pressure: _____

REQUIRED:

(Circle one)

Often transportation to camp is arranged via private small aircraft . . . In your opinion, is this child medically stable and able to fly in a non-pressurized small aircraft? **YES NO**

Does this child have any current conditions that you are treating or under your care? **YES NO**

If yes, explain: _____

Is this child under any type of medications, and/or other treatments that we should know about and therefore administer at camp? **YES NO**

If yes, explain: _____

Has this child had any past medical conditions that we should know about? (e.g. seizures, heart problems, broken bones, fainting, ear or eye conditions, etc.) **YES NO**

If yes, explain: _____

Any allergies and or dietary restrictions we need to know about? **YES NO**

If yes, explain: _____

Any activities to be encouraged or to be restricted? **YES NO**

If yes, explain: _____

Physician's Signature

Date

() _____ - _____
Physician Phone Number

Address:

Office Stamp Here:
(Optional)



Please mail all information to the Northern Region Office:
Alisa Ann Ruch Burn Foundation, Attn: Gypsy, 665 Third Street, Suite 345, San Francisco, CA 94107
If you have any questions please contact Gypsy: 1(800) 755- BURN • Fax (415) 495-7224 • sburton@aarbf.org