Camper Field Trip Medical Form

Please complete and return to the camp office by June 1st.
(only for campers attending field trips)

5461 Louise Ave.
Encino, CA 91316

or

Fax:
818.986.2605

Camper Information

Name: _____
(Last) (First)

Date of Birth: ____ / ____ /_____ **Age:** _____ **Sex (circle one):** Male Female
MM DD YYYY

Home Address: _____
(Street) (City) (State) (ZIP Code)

Home Phone: (____)_____ **Cell Phone: (____)_____**

Parent/Guardian #1

Name: _____ **Relationship to Camper:** _____

Home Address: _____
(If different from above) (Street) (City) (State) (ZIP Code)

Home Phone: (____)_____ **Work Phone: (____)_____** **Cell Phone: (____)_____**

Parent/Guardian #2

Name: _____ **Relationship to Camper:** _____

Home Address: _____
(If different from above) (Street) (City) (State) (ZIP Code)

Home Phone: (____)_____ **Work Phone: (____)_____** **Cell Phone: (____)_____**

Emergency Contact

*An additional contact is required in the case of an **EMERGENCY** and the Parent(s) cannot be reached.*

Name: _____ **Relationship to Camper:** _____

Home Phone: (____)_____ **Work Phone: (____)_____** **Cell Phone: (____)_____**

Medical Insurance Information

This camper is covered by family medical/hospital insurance: ❒ Yes ❒ No

Include a copy of BOTH SIDES of your insurance card, if applicable.

Insurance Company: _____ **Policy Number:** _____ _

Subscriber: _____ **Insurance Company Phone: (____)_____**

Name of Primary Care Physician: Phone: _____ **(____)_____**

Parent/Guardian Authorization for Health Care

This health history is correct and accurately reflects the health status of the camper for whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian: _____ **Date:** _____ **Relationship to camper:** _____