

Health Record for Camp Participation

Camper's Name _____ **Date of Birth** _____

Parent/Guardian _____

Home Address _____

City _____ Zip _____

Phone 1 _____ Phone 2 _____

Email _____

Second Parent _____

Home Address _____

City _____ Zip _____

Phone 1 _____ Phone 2 _____

Email _____

Emergency Contact _____

Home Address _____

Phone 1 _____ Phone 2 _____

Family Physician _____

Phone _____

Dentist _____

Phone _____

Health Insurance

Is camper covered by family medical/hospital insurance? Yes _____ No _____

Carrier _____ Policy or group # _____

Participation Requests or Limitations

Please indicate any pertinent information or requests regarding medical conditions which may limit or alter participation. Information regarding medications can be found on following pages.

Activity restrictions: _____

Dietary restrictions: _____

Medical treatments: _____

Health History

Camper's Name _____ Date of Birth _____

Immunizations:

Are immunizations complete and up-to-date prior to camp entrance? Yes _____ No _____

- | | Yes | No | Has camper had any... |
|----|-------|-------|---|
| 1 | _____ | _____ | Chronic or recurrent illness |
| 2 | _____ | _____ | Illness lasting over one week |
| 3 | _____ | _____ | Missing organs |
| 4 | _____ | _____ | Orthopedic injury/abnormality |
| 5 | _____ | _____ | Problems with heart or blood pressure |
| 6 | _____ | _____ | Chest pain with exercise |
| 7 | _____ | _____ | Dizziness or fainting with exercise |
| 8 | _____ | _____ | Frequent headaches |
| 9 | _____ | _____ | Convulsions |
| 10 | _____ | _____ | Concussions or unconsciousness |
| 11 | _____ | _____ | Heat exhaustion, heat stroke, or other problems with heat |

- | | Yes | No | Does camper... |
|---|-------|-------|--|
| 1 | _____ | _____ | Wear glasses/contacts |
| 2 | _____ | _____ | Wear dental braces/appliances |
| 3 | _____ | _____ | Take regular medication |
| 4 | _____ | _____ | Have environmental allergies |
| 5 | _____ | _____ | Have insect allergies |
| 6 | _____ | _____ | Have asthma or recurrent respiratory illness |
| 7 | _____ | _____ | Have intolerance to strenuous exercise |
| 8 | _____ | _____ | Have emotional/behavioral imbalances |

Use this space to explain any "Yes" answers above or to provide any additional information.

Emergency Authorization

I hereby give my permission to the personnel selected by the camp director to order routine treatment for my child, and in the event that I cannot be reached in an emergency. I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injections, anesthesia, or surgery for my child named above.

Signature of parent/guardian _____ Date _____

PHOTO WAIVER

_____ I hereby permit Polar Ice Ventures, Inc. to use pictures/videos taken at camp in which myself/or my child may appear, for purposes of communications and literature about the rink or face painting.

The Polar Ice House would like to thank you for your cooperation.