2017 MEDICAL FORM - Mail to: Journey Camp, P.O. Box 65, Shelburne Falls, MA 01370

Name of child:____ Age: ____ Date of birth:_______________

Home address:____

EMERGENCY INFORMATION

PHONE NUMBERS: Give helpful details about the times people can be reached at these numbers:

* First person to contact in case of emergency **(easiest person to reach)**:

Name of parent/guardian:	HOME	WORK	CELL
____	_____________	______________	_____________

*Second person to contact in case of emergency:

Name of parent/guardian/relative/friend:	HOME	WORK	CELL
____	_____________	______________	_____________

* Third person to contact in case of emergency:

Name and relationship:	HOME	WORK	CELL
____	_____________	______________	_____________

PLEASE SIGN: I authorize emergency medical care for my child named _________________________.

Parent signature of agreement: ____

Name of Family Physician or Health Care Provider: ______________________________________

*******IMPORTANT*****
Phone Number of Physician/Health Care Provider: _______________________________

HEALTH PLAN/ INSURANCE COVERAGE: ____

MEDICAL INFORMATION - **Must be signed by parent or health care provider!**
DATE OF PHYSICAL EXAM conducted during preceding 24 months: _____________

Allergies?

Any injuries, medical conditions or restrictions?

Other relevant health history?

Required medications?

PLEASE NOTE: In order to **administer** at camp any medication from home, we will need written authorization from you and clear written instructions. Enclose a letter.

IMMUNIZATION RECORD: (please list dates)

Poliomyelitis	Tetanus	Measles	
Diphtheria	Mumps	Pertussis	Rubella

TUBERCULOSIS TEST RESULT: ___ negative ___ positive date:

Options: Attach photocopy of immunizations from your child's medical records.
Include a letter if you have a religious or medical reason that your child has not been immunized.

IMPORTANT: SIGNATURE of parent or a licensed health care provider: _________________________________