

Information & Questionnaire

Camper's Name _____ Date: _____

Parent/ Guardian Name: _____

Name of physician/Health care provider: _____

Physician/ Health care provider Phone Number: _____

Asthma

Does your child have asthma? ____ Yes ____ No

If yes, will medication be required to be administered during camp hours? ____ Yes ____ No

Food Allergies

Does your child have food allergies? ____ Yes ____ No

What food(s): _____

What happens: _____

Epi-pen

Does your child have Epi-pen? ____ Yes ____ No

If yes, will medication be required to be administered during camp hours? ____ Yes ____ No

ADHD / ADD

Has your child been diagnosed with **ADHD or ADD**? ____ Yes ____ No

Is your child on any medication? ____ Yes ____ No

IF YES TO ANY QUESTIONS, PLEASE FILL OUT MEDICATION ORDER FORM

Does your child have any **emotional problems**? ____ Yes ____ No

Explanation: _____

Please indicate your child's health condition and symptoms so that we can recognize and give any special care needed: _____

Please describe, in detail, the usual symptoms, so that we may recognize the condition or any deviation from the usual reaction: _____

How do you treat this at home? _____

How would you like us to respond to this at camp if it becomes necessary? _____

If you have any questions concerning this form please call the camp manager at 240-997-1700.

Signature of Parent/Guardian: _____ Date _____