

# CAMPER MEDICAL HISTORY

Camper's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone#: \_\_\_\_\_ Email: \_\_\_\_\_ Grade: \_\_\_\_\_ Age: \_\_\_\_\_

## Parents' Names and Phone Numbers During Camp Hours

Mother: \_\_\_\_\_ Phone: \_\_\_\_\_  
Father: \_\_\_\_\_ Phone: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

## HEALTH HISTORY: (Circle any that apply)

Chickenpox      Mumps      Earaches      Seizures      Ivy oak allergies  
Heart problems      Glasses/Contacts      Diabetes      Sinus problems

Drug allergy (specify) \_\_\_\_\_

Food allergy (specify) \_\_\_\_\_

Documented Chicken Pox/Varicella Vaccine      Environmental/Seasonal Allergies

Asthma/Reactive Airway Disease      Bee/hornet sting allergy

Detail any of the above: \_\_\_\_\_

Medications being taken (name and explain): \_\_\_\_\_

Operations, injuries, special restrictions (give dates): \_\_\_\_\_

## IMMUNIZATIONS Date: Booster:

Diphtheria: \_\_\_\_\_

Tetanus: \_\_\_\_\_

Pertussis: \_\_\_\_\_

Polio: \_\_\_\_\_

Measles: \_\_\_\_\_

Mumps: \_\_\_\_\_

Rubella: \_\_\_\_\_

Hepatitis B: \_\_\_\_\_

Date of last physical examination (must be within last 24 months): \_\_\_\_\_

**I certify that the above medical information is complete and accurate.**

Physician Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

## CONSENT FOR MEDICAL TREATMENT [Minor]

As Parent or Legal Guardian of \_\_\_\_\_, I hereby give my consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve life, limb or the well being of my dependent. I understand that the directors, or anyone associated with France Exchange Services will not assume responsibility for accidents & medical or dental expenses incurred as a result of participation in this program. The applicant is covered by our family insurance, is in good health, and able to participate in the physical activity of our program. I hereby authorize the camp directors or anyone associated with France Exchange Services to act for me according to their best judgment in any emergency requiring medical attention. I will hold harmless France Exchange Services of all liability actions, causes of action, claims & demands of every kind and nature whatsoever which may arise in connection either with or resulting from participation in any of its activities.

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Family Health Insurance Company & Policy #: \_\_\_\_\_

***(Required for ALL campers before being accepted to camp)***

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