HUNT HILL AUDUBON SANCTUARY MEDICAL FORM
CHILDREN AND YOUTH

PROGRAM:____DATE: _________________
FULL NAME:____
Street, City, State, Zip:____
PHONE: (H) ______________________(C)_________________________(W)___________________
DATE OF BIRTH:_______________________ AGE: _________________

Our camp provides first aid only. In the event of illness, or injury, a doctor will be called at the participant's expense. In an emergency, the camper will be transported to Spooner Memorial Hospital, unless preference is noted here: ____________
____

In case of emergency, who should be notified?

NAME: _____________________________________ RELATIONSHIP:________________________
STREET: ____________________________________ PHONE: (H) ___________________________
CITY: ________________STATE_____ZIP________ (C) ___________________(W)_____________
FAMILY DR: _________________________________CLINIC__________________________________
ADDRESS____PHONE_______________________

HEALTH CONDITIONS AND ALLERGIES

Are your activities in any way limited now?____
____
Have you been ill recently? ______With what? ____
Are you allergic to any medication? (specify) ____
____
Are you allergic to insects or plants we might encounter on a fieldtrip? ___________________________
____
____
Are you currently taking any medication the staff should be aware of? _________________________
____
Approval to give: Motrin ______ Tylenol ____Benadryl ___Date last tetanus booster: _____________

DIETARY NEEDS AND FOOD ALLERGIES

Please list any special dietary needs or food allergies that our staff should be aware of when preparing meals:
____
____
____
____

PAST MEDICAL HISTORY

Any history of asthma or severe allergic reaction? ____
Previous surgery? ____
Previous severe injuries (broken bones – major trauma)? ____
____
Previous hospitalization? ____
Any problem requiring regular medical attention? ____
____

Signature: ____*Date*________________________