



CONTACT INFORMATION

Bring it to Camp Shocco on July 1st with INSURANCE CARD

Full Name: _____ Birthday: _____ Age: _____

Parent/Guardian: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Mobile Phone Number: _____

Work Phone Number: _____

In Case of Emergency: _____ Relationship to Child: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Mobile Phone Number: _____

Work Phone Number: _____

Family Physician: _____ Office Phone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

HEALTH HISTORY

Diseases

If you had one or more of diseases listed below, please give approximate dates.

<input type="checkbox"/> Frequent Ear Infections	<input type="checkbox"/> Chickenpox	<input type="checkbox"/> Frequent Colds
<input type="checkbox"/> Sore Throats	<input type="checkbox"/> Measles	<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Mumps	<input type="checkbox"/> Strep Throat	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Polio
<input type="checkbox"/> Bleeding/Clotting Disorders	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Asthma	<input type="checkbox"/> Stomach Problems	<input type="checkbox"/> Arthritis

Other diseases or details of above: _____

Allergies

Please check if you have one or more of allergies listed below.

<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Poison Ivy	<input type="checkbox"/> Oak Sumac	<input type="checkbox"/> Insect Stings
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Aspirin		

Drug(s): _____
 Food(s): _____
 Other allergies: _____

Subject To

<input type="checkbox"/> Sleep Walking	<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Fainting	<input type="checkbox"/> Constipation
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Other: _____

HEALTH HISTORY

Recent Exposure to Contagious Disease(s): _____

Operations or Serious Injuries (describe and give approximate dates): _____

Are Immunizations up to the date? _____ If no, explain _____

Date of Last Tetanus Shot: _____ Date of Last TB Skin Test: _____

Any Swimming, Diving, or Activity Limitations? _____

Any Special Medical or Dietary Regime to be Continued? _____

Current Medications: _____

Any Specific Activities to be Encouraged? _____

Any Specific Activities to be Restricted? _____

Hearing Device(s)

What Kind of Hearing Device(s): _____

Serial Number(s): _____

Color(s) of Hearing Device(s): _____

Color(s) of Ear Mold(s): _____

I understand and agree that Camp Shocco for the Deaf is not responsible for the damages / loss of hearing devices. (Initials of Parent/Guardian) _____

IMPORTANT - THE INFORMATION BELOW MUST BE COMPLETED FOR ATTENDANCE

The **Health History** is correct so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted.

Emergency Authorization - I hereby give permission to the medical personnel selected by Shocco's Director/Nurse to order X-rays, routine tests and treatment for my child. In the event of an emergency and I cannot be reached, I hereby give permission to the physician selected by Shocco's Director to hospitalize, secure proper treatment, order injections and/or anesthesia and/or surgery for my child as named above.

I further authorize the release of the above medical information to appropriate medical personnel and/or the health coverage insurance company.

Signature of Parent/Guardian

Witness

Date

I _____ understand and agree to abide with the restrictions placed on my activities by
Name
my parent/guardian.

Signature of Child Participant

INSURANCE

(Verify accuracy of insurance information - Insurance carrier's address is essential.)

Insurance issued in the name of: _____

Address of insured: _____
Street or Box City State Zip

Date of Birth of Insured: _____ Is this coverage for a dependent? _____

If so, give name of dependent: _____ Relationship: _____

Name of Insurance Company: _____

Address of Insurance Company: _____
Street or Box City State Zip

Telephone Number: _____ Policy Number: _____

PLEASE ATTACH A PHOTOCOPY OF BOTH SIDES OF YOUR HEALTH INSURANCE CARD.

I understand that my insurance will be filed as the primary carrier. In the event that no insurance is provided by the family, Shocco Springs Medical Supplement will be the primary within the prescribed limits.

Signature of Parent/Guardian