

CAMP BRAVO HEALTH FORM

Participant Name _____ Birth Date _____

Parent / Guardian _____ Camper Gender _____
(If camper is a minor)

Week (s) Registered Week 1 Week 2 Week 3 Week 4 Teachers Retreat

● HEALTH HISTORY ●

Names of medication currently being taken _____

Dosage _____ Specific times taken each day _____

NOTE: Participants must bring enough medication for the entire week. Please send medication properly labeled with the patients name in ORIGINAL containers. For all minors, all medication including over the counter, will be collected and distributed by the camp nurse.

Is applicant under physician's care? _____ Date of last Tetanus Booster _____

Do you have allergic reaction to? Bee Stings _____ Drugs _____ Foods _____ Other _____

If yes, please explain _____

Do you have any physical restrictions? _____

Do you have any other recurring medical conditions? _____

Please list any other pertinent medical / health information (ie: asthma, heart disease, emotional difficulties...)

IMPORTANT: Please notify Camp Bravo if camper was exposed to any communicable disease during the four weeks prior to camp.

● INSURANCE INFORMATION & LIABILITY RELEASE ●

de Benneville Pines Camp asks that everyone is covered by medical insurance. Please provide the following information.

INSURANCE CARRIER _____ PHONE _____

POLICY NUMBER _____

ADDRESS _____

This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to Camp Bravo to provide routine health care, administer prescribed medication and seek emergency medical treatment. I agree to release of any records necessary for treatment, referral, billing or insurance purposes.

IN CASE OF EMERGENCY, I hereby give permission to the hospital, physician, dentist or licensed medical personel to provide proper emergency treatment: this includes but is not limited to the administration of injections, anesthesia, and/or emergency surgery as deemed necessary by my or my childs condition. If the participant is a minor, I understand that every reasonable attempt will be made to contact parent / legal guardian prior to such treatment. This completed form may be photocopied for trips out of camp.

SIGNATURE _____ DATE _____

Adult Participant or Parent / Legal Guardian

THE BOX BELOW IS FOR ALL STUDENTS UNDER THE AGE OF 20 ONLY

Health care recommendation by licensed medical personalis required for all MINORS to participate in camp

I have examined the above applicant on _____ (a new exam is not necessarily required for camp attendance)

In my opinion, the applicant is is not able to participate in an active camp program.

Physicians signature

Date

Camp Bravo MUST receive a completed copy of Health Form at least 2 weeks prior to the start of camp.
Camp Bravo provides this form as a courtesy. We accept no responsibility for its accuracy or completeness.

Camp Bravo: 19360 Rinaldi St. #406, Northridge, CA. 91326