



Invent. Guide. Balance. Link. Sustain. Delight. Reflect.

CAMPER HEALTH HISTORY

Beam Camp, 6 Second Place, Brooklyn, NY 11231
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CONFIDENTIAL

Please complete, sign and return this form along with a copy of child's most recent medical exam and **both sides of your child's health insurance card** by **June 1st**.

CAMPER LAST NAME **CAMPER FIRST NAME**

Birthdate _____ Age _____ M F

PARENT/GUARDIAN Relationship

Home Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____ Email _____

PARENT/GUARDIAN Relationship

Home Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____ Email _____

PARENT/GUARDIAN Relationship

Home Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____ Email _____

FAMILY PHYSICIAN Phone

HEALTH INSURANCE COMPANY

Address _____ City _____ State _____ Zip Code _____

Subscriber _____ Relationship _____ Birthdate _____

ID Number _____ Policy/Group # _____ Prescription Plan Name and # _____

Health History (Check all that apply and give approximate dates)

Conditions

- Frequent Ear Infections _____
- Heart Defect/Disease _____
- Convulsions/Seizure disorder _____
- Diabetes _____
- Bleeding/Clotting disorder _____
- HIV _____
- Eating Disorder _____
- ADHD _____
- Asthma _____
- Epilepsy _____

Diseases

- Mononucleosis _____
- Chicken Pox _____
- Measles _____
- German Measles _____
- Mumps _____
- Hepatitis _____

Allergies

- Hay Fever _____
- Poison Ivy _____
- Insect stings _____
- Penicillin _____
- Other _____

CAMPER LAST NAME _____

CAMPER FIRST NAME _____

Operations and/or serious injuries (dates) _____

Disability and/or chronic recurring illness _____

Any specific activities to be encouraged or limited by physician's advice _____

Other diseases or details of above _____

Dietary Modifications/Restrictions or Preferences:

Has camper been under the care of a physician, psychologist or psychiatrist within the last year? Yes No

If yes, please explain _____

Is the camper currently in treatment? Yes No If yes, please provide information for therapist/counselor:

Name _____ Phone _____

Are there any social, emotional, physical problems or events that your child has experienced in the last few years that might affect him/her while at camp? (Recent death in the family, divorce, etc.)

Is there any other information about this camper that would assist us in meeting his/her needs? Please explain.

Please attach a copy of your child's last medical examination from a licensed physician if available.

Please attach a copy of both sides of your medical insurance card.

This health history is correct to the best of my knowledge and the person described has permission to engage in all camp activities except as noted. The camper enrolled herein is healthy and free of problems that could adversely affect his/her stay at camp or that of other campers at Beam Camp.

Emergency Authorization: I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests and treatment for my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize; secure proper treatment for; and order injections, and/or anesthesia, and/or surgery for my child as named above. This form may be photocopied for use out of camp.

Signature or Parent/Guardian _____ Date _____