



Camp Choconut

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Winter address: 5790 Robin St., St. Paul, MN 55126

(651) 338-3042

www.campchoconut.com

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STAFF

Staff Name _____ Age ____ DOB __/__/_____

MEDICAL

Address _____ Grade _____

HISTORY

__ **Check here** if separate sheets have been attached to provide additional information.

Have you had in the past year:	No	Yes	Please explain "yes" answers and give dates.
Any injuries requiring medical attention?			
Any surgical operations or hospitalizations either medical or mental?			
Convulsions or seizures for which you are being treated?			
Recurrent headaches?			
Asthma, breathing difficulty or cough with exercise? Inhaler?			
The use of only one eye or a history of any injury to the eye?			
Heart murmur, heart problems, history of rheumatic fever?			
Has any member of your family died suddenly of a heart-related issue?			
High blood pressure?			
Only one kidney or one or both testicles not descended?			
Any problems with neck, back, shoulder, hips, or knees?			
Diabetes (sugar)			
Hemophilia (are you a bleeder?)			
Anorexia, bulimia or eating disorder?			
Mononucleosis?			
Chest pain with exercise?			
Do you tire quickly?			
Had any allergic reaction to medications or insects?			

Staff Name _____

Wear glasses, contacts or medical braces during sports activity?			
Is any doctor currently treating you for any disorder?			
Are you currently taking any medications?			
Any problems with your health that might affect your ability to participate in athletic activities?			
Do you know of any reason why you should not participate in any specific athletic activity?			

Release:

In the event of a medical emergency, I grant permission for the staff of Friends of Camp Choconut, Inc. to perform supportive measures until I can be contacted, professional medical personnel can attend, or transportation to a medical facility can be arranged. I authorize the Camp Director, or a person authorized by him, to make decisions regarding the medical care of my child. I also certify that the answers to the above answers are correct and true.

Signature (Parent/Guardian) _____ Date _____

Doctor's Statement:

I certify that _____ has had a physical in the last two years, that he is current with all his vaccinations (including tetanus), and that he is in good physical condition to participate in all the activities at Camp Choconut.

Doctor's Signature _____ Date _____

Doctor's Printed Name _____ Phone () _____

Medical Insurance:

Company _____ Phone: _____

Account number(s): _____

Please include a copy of yours or your child's Insurance Card