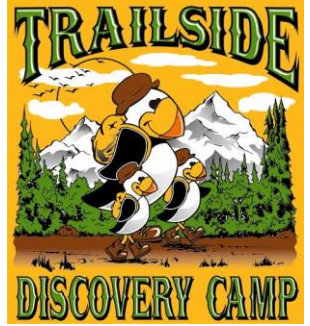


Trailside Discovery Medical Form



Camper's Full Name: _____

DOB:	Grade:	Gender: M / F	Height:	Weight:
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Camper Ethnicity (Please circle one): American Indian, / Alaska Native / Asian / African American / Native Hawaiian or Other Pacific Islander / Caucasian, OTHER: _____.

Household Information

Parent 1:	DOB:	Parent 2:	DOB:
Home:	Cell:	Home:	Cell:
Email:	Email:		
Address:	City:	State:	Zip Code:

Emergency Contacts

Name:	Relationship:	Home:	Cell:
Name:	Relationship:	Home:	Cell:

Health History

Medical Conditions

- ADD/ADHD
- Back Pain
- Behavior Issues
- Ear Infections
- Fetal Alcohol Syndrome
- Hay Fever
- Headaches
- Hearing Problems
- High Blood Pressure
- Homesickness
- Kidney Disease
- Menstrual Difficulties
- Mental Health Issues
- Other _____

Explain checked conditions:

Allergies, Restrictions, & Injuries

- 1) **Does your child require an EpiPen?** YES NO
(Yes) Date and description of the last reaction: _____
- 2) **Does your child have any dietary restrictions?** YES NO
(Yes) Explain: _____
- 3) **Surgeries or injuries we should be aware of?** YES NO
(Yes) Explain with date of incident(s): _____
- 4) **Does your child require any special accommodations?** YES NO
(Yes) Explain: _____
- 5) **Has your child been exposed to any communicable diseases within the last 3 months?** YES NO
(Yes) Explain Disease(s) and date of exposure: _____
- 6) **Please list any other medical information the camp should have:** _____

Health Insurance

Policy Holder Information Family Doctor

Full Name:	Contact Number:
Insurance Company:	Ins. Contact Number:
Group Name/Number:	Policy Number:
Clinic Name:	Contact Number:
Physician Name:	

I HAVE READ THIS FORM, AND THE PARENT POLICY FORM. I AGREE TO ITS TERMS AS NOTED, AND I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE AND COMPLETED TO THE BEST OF MY KNOWLEDGE.

Legal Guardian Signature:	Date: _____
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Thank you,
Thomas Burek

Thomas Burek

Trailside Camp Director

