

"JUST HORSIN' AROUND"

Summer Equestrian Day Camp 2012

850 CR 342 Poteet, TX 78065

Owner/Operator Karen Harris (830)570-9222

[Return to Camp Director](#)

MEDICAL HISTORY AND

PHYSICIAN RELEASE TO PARTICIPATE

Name _____ Date of Birth _____ Age at Camp _____

First Middle Int. Last

Address _____

Gender _____ Female _____ Male

Parent/Legal Guardian Name _____

Phone #'s home _____ cell _____ work _____

Emergency Contact other than Parent Name _____

Relationship to Parent _____

Address _____

Phone #'s home _____ cell _____

Is the camper covered by family medical insurance? Yes _____ No _____

Health Insurance Provider _____ Phone # _____

Parent Name: _____

Health History

The following information must be filled out by parent/guardian. The intent of this information is to provide camp personnel the background to provide appropriate care. Please provide up-to-date, accurate information so the camp can be aware of camper's specific needs.

Allergies List all know.

Describe reaction & management of the reaction

Medication Allergies

- | | |
|----|----|
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |

Food Allergies

- | | |
|----|----|
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |

Other Allergies

- | | |
|----|----|
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |

Medication Being Taken routinely: Please list ALL medications currently being taken, Rx and OTC(over-the-counter).

_____ Camper takes NO current medications on a routine basis.

_____ Camper takes medications as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #3 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Attach additional information as needed.

DIETARY Restrictions List ALL

Explain ANY restrictions to Activities:

General Questions: If YES to any , please explain below.

NO YES

1. Any recent injury, illness, surgery?
2. Frequent Headaches?
3. Wears contacts or eyeglasses?
4. Ever had seizures, dizziness or passed out?
5. Ever had joint problems, broken bone(s)?
6. Any major medical condition: asthma, diabetes, etc?
7. Any emotional difficulties in which professional help was sought?

Please explain any "YES" answers:

The applicant is current on all vaccines? Yes _____ No _____

Name of Family Physician _____ Phone # _____

Preferred choice of Medical Treatment facility _____

Name of Family Dentist _____ Phone # _____

This health history is correct and complete as far s I know. The person herein named has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of medications, and emergency treatment for my child as necessary. It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is a minor. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person herein named.

Signature of Parent/Legal Guardian _____ Date _____

Printed Name _____

Health Care Recommendations by Licensed Medical Personnel

Child's Name _____ Date of Birth _____ Age _____

I examined this individual on _____

In my opinion, the above individual is _____ is not _____ able to participate in an active summer camp program.

The applicant is under the care of a physician for the following reasons:

Recommendations/ Restrictions at Camp:

_____ No recommendations or restrictions at camp.

If Yes, Explain:

Signature of Licensed Medical Personnel _____

Printed _____ Title _____

Address _____

Phone # _____ Date _____