Confidential Medical Form

Camp Ma Rabu ~ 10714 Meadowhill Road ~ Silver Spring, MD ~ 20901

Please return *this* original medical form. *Faxed copies and other medical forms will not be accepted.*

Name_____ Date of Birth_____ Age_____

Parent/Guardian_____ Phone #_____

Address_____ City_____ State_____ Zip code_____

Business Telephone #_____ Summer Address & Telephone #_____

TO BE COMPLETED BY PARENT/GUARDIAN:

Check if child has or had the following conditions:

- ☐ Clotting Disorder
- ☐ Serious Injury
- ☐ Recurring Illness
- ☐ Food Allergy
- ☐ Eating Disorder
- ☐ Diabetes
- ☐ Heart Condition
- ☐ Behavioral Issues
- ☐ Seizure
- ☐ Epilepsy
- ☐ Disability
- ☐ Bee Sting Allergy
- ☐ Allergy Medication
- ☐ Asthma

Other Conditions:_____

Please indicate history of above and medication and/or treatment to be continued at camp_____

_____

Would you like us to be aware of anything specific to assist us in the care of your child? (i.e. frequent colds, ear infections, stomach problems, diarrhea, nausea, vomiting, constipation, insect bites, homesickness, and anxiety.)_____

☐ Please check if you have anything confidential that you would like to discuss with the Director prior to your child's arrival at camp.

TO BE COMPLETED BY EXAMINING PHYSICIAN:

Vaccines	Dates of Basic Immunization	Booster
DPT-DT-Tetanus		
MMR		
Polio		
Hepatitis A		
Hepatitis B		
HIB		

I have examined the above named applicant. Date examined_____

In my opinion this condition does___/does not____preclude participation in an active camp program

Patient was found to be in normal good health with the following exception:_

_____

Patient's Blood pressure_____ Patient's Heart Rate_____

Patient's Height_____ Patient's Weight_____

Patient has the following allergies_____

Medication and/or treatment to be continued at camp_____

_____

Physician's Signature_____ Date_____

Physician's Name and Telephone:_____

IMPORTANT!

This Box must be completed for attendance.

I, the undersigned, parent/guardian of (Camper's Name)_____, a minor, do hereby authorize Camp Ma Rabu as our agent to consent to any diagnostic procedure or medical care which is deemed advisable by, and is rendered under the general or special supervision of any licensed physician and surgeon at a hospital and/or doctor's office.

It is understood that this authorization is given in advance of any specific need for treatment but is given to provide authority on the part of the aforesaid agent to give specific consent to any and all such diagnosis, treatment, or hospital/ private doctors which the physician exercises his/her best judgement may deem advisable.

The authorization shall remain effective, unless revoked in writing and delivered to the said agent.

Parent/Guardian Signature_____

Date:_____

Parents please fill out YOUR insurance information below:

Medical Insurance Carrier: _____

Policy/ Group #:_____

Do you need prior approval for medical care?

Yes

No

Parents please paste and/or staple a copy of your insurance card in the designated box below

Please Paste/staple COPY of the FRONT of your Insurance and Prescription Card.

Please Paste/staple COPY of the BACK of your Insurance and Prescription Card.