AMOA Summer Camp Health Form

Camp: ☐ Sculpture ☐ Ceramics ☐ Animation ☐ 2D ☐ Digital Animation ☐ 3D Printing

The health form is kept confidential and will only be used by AMOA staff (or emergency medical personnel) in case of an emergency. **Every camper needs a completed health form to participate in any summer camp programs. Please fill out this form as completely as possible. Thank you!**

SECTION I – BASIC CONTACT INFORMATION

Campers Full Name: _____

Birth date: _____/_____/_____ Age: _____

Gender: _____Male _____Female Home Phone: _____

Home Address: _____

Parent/Guardian #1

Name:_____

Relationship: _____

Day Phone: _____

Parent/Guardian #2

Name:_____

Relationship: _____

Day Phone: _____

Family Physician Name: _____ Phone: _____

Dentist/Orthodontist Name: _____ Phone: _____

SECTION II – INSURANCE INFORMATION

If the camper is covered by family medical/hospital insurance please fill this section out as completely as you can.

Carrier: _____

Group #:_____ Policy #:_____

Policy Holder's Name: _____

Relationship to participant: _____

SECTION III – MEDICATIONS

Will camper be taking medications while at camp? ____Yes____ No
(Medications include prescription, inhalers, etc.)

If camper will be taking medications while at camp, it is Indiana state law to secure your consent for medication distribution and for the use of medical devices. The medication can be self-administered (if over 18) or administered by Staff. Please list all (prescription and non-prescription). Include the medication name, prescribing physician, physicians' phone number, and the dosage instructions. Use an additional sheet if needed. When you check-in at camp, please provide all medications (in their original packaging that identifies the prescribing physician (if prescription drug), the name of the medication, the dosage, and frequency of administration.

_____ I want the medication or medical devices self-administered.

_____ I want the medication or medical device administered by the Staff.
However, a limited amount of medication for life threatening conditions should be carried by my son/daughter/ward. (i.e. bee sting kits, inhalers)

Medication: _____ Dosage: _____

Take at what times: _____

Reason for Taking: _____

Prescribing Physician: _____

Phone: _____

SECTION IV – ALLERGIES + HEALTH HISTORY

_____ Camper does not have any allergies

_____ Camper is allergic to: Insect Stings _____ Food _____ Other_____

Please list allergy. Describe reaction and treatment:

_____

_____

Does the camper have any physical limitations or restrictions in regards to physical activities?

_____

_____

SECTION VI – AUTHORIZATION

My child has permission to engage in all prescribed camp activities except as noted. The information provided on this form is accurate to the best of my knowledge. I have indicated any special health conditions, including required medication and activity limitations which should be known to the camp staff and medical personnel. I am aware of and accept the risk inherent in the program activity. I give consent in advance for medical treatment at an appropriate facility in case of illness or injury.

Signature of Parent or Guardian

X_____ Date_____