

**MN ELK'S YOUTH CAMP  
HEALTH EXAMINATION FORM**

**To be completed by the parent:**

Name: \_\_\_\_\_ Sex: F M Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Parent or Guardian \_\_\_\_\_ Phone: \_\_\_\_\_

In emergency notify \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Dentist/Orthodontist \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you carry family medical insurance? \_\_\_\_\_ If so, Name of Insurance Company \_\_\_\_\_ Policy or Group # \_\_\_\_\_

Please list any meds sent with child \_\_\_\_\_ The camp nurse/aid will be administering these meds.

**PARENT'S AUTHORIZATION: This information is correct and the person herein described has permission to engage in all prescribed camp activities except as noted by me and the examining physician. I hereby give permission to the physician selected by the camp director to order X-rays, routine tests and treatment for the health of my child, and in the event I cannot be reached in an emergency. I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above.**

**Signature** \_\_\_\_\_ **Name Printed** \_\_\_\_\_



**Recommendations and Restrictions at Camp**

Treatment to continue at camp \_\_\_\_\_

Medication to be administered at camp (name, dosage, frequency)  
\_\_\_\_\_

Known Allergies (Food, medication, or other)  
\_\_\_\_\_

Description of any limitation or restriction on camp activities  
\_\_\_\_\_

**Dietary Restrictions**

Please list any dietary restrictions that apply to this individual \_\_\_\_\_

Please obtain a copy of your child's physical within the last year and attach it to this health form. We will keep this physical on file for up to 3 years.

We reserve the right to complete a health screening of each camper upon their arrival in order to be aware of any health concerns.