

Westview Retreats

Medical History and Permission to Treat

Name of Participant (print) _____ Date of Birth _____

IMPORTANT-Please be thorough in providing the information requested. Failure to disclose information could result in serious harm.

IF YOU CHECK YES TO ANY QUESTION BELOW, DESCRIBE DETAILS BELOW APPROPRIATE QUESTION.

Attach an additional sheet if necessary.

1. Do you have any medical problems or physical limitations? YES ___ NO ___

2. Does your health prevent you from participating in any physical activities? YES ___ NO ___

3. Are you taking any prescription or non-prescription medications?
(Please list all, reasons for taking, and how often needed) YES ___ NO ___

4. Are you allergic to any insect bites or medications? YES ___ NO ___

5. Do you have impairments of vision or hearing? YES ___ NO ___

6. Are you engaged in a regular program of exercise?
(Describe exercise and frequency) YES ___ NO ___

7. Do you have asthma? (Describe) YES ___ NO ___

8. Do you have problems with your neck, back, arms, shoulders, ankles or knees that
may limit your activities? YES ___ NO ___

9. Do you have ADD or ADHD? (If yes, explain) YES ___ NO ___

AUTHORIZATION FOR TREATMENT: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment and necessary transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child as named above.

Signature of Parent or Guardian or Adult Camper/Staff _____

Date _____