CAMP ABLE
At Coronado

HEALTH HISTORY

Conditions and limitations, which may effect the camper's participation, must be reported on this application.

1. Has the camper had a health examination within 24 months prior to camp? Yes___ No___
2. Has the camper had the required immunizations? Yes___ No___
   Polio: Date_____ DPT: Date_____ MMR: Date_____
3. Does the camper have allergies: Yes___ No___ Describe:
   _____
   _____
4. Does the camper have a disability or health problem? Yes___ No___
   If "yes", what is the diagnosis?
   _____
   _____
5. Does the camper have seizures? Yes___ No___
   If "yes",
   describe:_____
6. Does the camper take medication? Yes___ No___
   If "yes", what medication?
   _____
   _____
7. Are there any other conditions or limitations which may effect the camper's participation at Camp Able (wheelchair, walker, braces, etc.)? Yes___ No___
   If "yes",
   describe:_____
8. Does the camper need special attention for feeding/toileting/dressing? Yes___ No___
   If "yes",
   describe:_____
9. Will the camper require the services of the Camp Able Nurse for medical treatment or for administering medication? Yes___ No___
   IF "YES", A SEPARATE MEDICAL FORM MUST BE SUBMITTED.
10. Summarize past medical
    treatments:_____
    _____
11. Primary Health Care Provider/
    Physician:_____Phone:_____

PARENTAL/GUARDIAN PERMISSION

I give my permission for the above named camper to participate in the Camp Able Program. I authorize emergency medical treatment at the hospital designated by the emergency medical personnel. I authorize emergency first aid by the Camp Able registered Nurse or the Camp Able Certified Staff. Yes_____
No_____
SIGNATURE:_____ NAME
(PRINT):_____
RELATION:_____ E-MAIL
_____

I give my permission for the above named camper to be photographed at Camp Able for publicity purposes.
Yes___ No___ SIGNATURE:_____ NAME
(PRINT):_____
Relation:_____