



**Allergies**

Camper is allergic to the following foods:.....

Describe the reaction (anaphylaxis, etc.) if this food is consumed and what is done to manage it: .....

.....

Camper is allergic to the following medications: .....

.....

Camper is allergic to the following substances: .....

Describe the allergic reaction: .....

.....

**Diet**

Please check one:

- Camper eats a regular and varied diet.
- Camper eats a limited diet (Please be specific):.....

Is camper lactose-intolerant?  Yes  No

- If yes, please check one:
- Camper uses a product like Lactaid and/or can self-manage the intolerance.
  - Camper requires a lactose-free diet

Is camper gluten-intolerant?  Yes  No

Other dietary restrictions: .....

**Chronic Concerns**

Camper has the following chronic health concerns:

- Asthma
- Menstrual cramps
- Headaches
- Frequent ear infections
- Diabetes
- Frequent colds
- Skin Conditions (explain)
- Other (please be specific): .....

Please provide information about supportive health care needed for each checked item:.....

.....

**Medications**

If your child must take medication while at camp, please note that here. **Do not give your camper's medication to him or her to bring to camp; adhere to the following guidelines.**

You must provide a full summer's worth of medication on Get Acquainted Day. All medications must be in their original containers and be appropriately labeled, and we must have a note from your child's doctor detailing the medications, doses, and administration instructions for all prescription medications.

Camper takes the following routine medications (excluding vitamins).

Name of medication:..... Name of medication: .....

Reason for Taking:..... Reason for Taking: .....

Dosage:..... Dosage: .....

How often/what times:..... How often/what times: .....



**Health Insurance**

It is essential for us to have your child's insurance coverage information on file. There is no charge for health care received from camp medical staff. In the event that outside diagnostic or treatment services are required while your camper is at camp, the family's insurance plan will be primary.

Name of parent through whom your insurance plan is written:.....

Name of Insurance Company:.....

Plan Name:..... Type:..... Card Number:.....

If this plan is a group plan provided through an employer...

Employer's name:.....Group number: .....

Type: .....

Card Number: .....

**Parent's Authorization**

The health information provided here and in other related documentation is correct and complete as far as I know. This camper has permission to participate in all camp activities except as otherwise noted in writing.

I give permission to the camp to provide routine health care, administer prescribed medications, and initiate outside medical treatment. I agree to the release of any records necessary for insurance or treatment purposes. I give permission to the camp to arrange necessary related transportation for my child. In the event that I cannot be reached in an emergency, I give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form and other information may be photocopied or faxed, and those copies should be considered as valid as the original.

Signature of Parent .....

Printed Name..... Date.....

Additional forms are available at <http://ColemanCountry.com/forms/>



**COLEMAN FAMILY**

C A M P S

**For Camp Use Only**

.....  
.....  
.....  
.....  
.....  
.....  
.....