

# RYLA PERSONAL HEALTH AND MEDICAL SUMMARY

To be filled out by parent or guardian

Name \_\_\_\_\_

## IDENTIFICATION

Name \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_

Name of parent or guardian \_\_\_\_\_ Daytime Phone (\_\_\_\_) \_\_\_\_\_

Nighttime Phone (\_\_\_\_) \_\_\_\_\_

Home address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Business address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

If person above is not available in the event of an emergency, notify:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name of personal physician \_\_\_\_\_ Phone \_\_\_\_\_

Cabin \_\_\_\_\_

## MANDATORY INFORMATION

Personal Health/Accident insurance carrier  Yes  No Name \_\_\_\_\_

Policy # \_\_\_\_\_ Carrier phone # \_\_\_\_\_

In case of emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the physician selected by the adult in charge to secure proper treatment which may include hospitalization, anesthesia, Surgery or injections of medication including over-the-counter medications as needed and as administered by the camp nurse.

Date \_\_\_\_\_ Signature (Parent or guardian) \_\_\_\_\_

Medical information past or present (please check)

Asthma  Yes  No

Allergies  Yes  No

Convulsions  Yes  No

Heart disease  Yes  No

High blood pressure  Yes  No

Diabetes  Yes  No

Leukemia  Yes  No

Cancer  Yes  No

Hemophilia  Yes  No

Please explain \_\_\_\_\_

Any reason to restrict full activity including swimming, sports, hikes, strenuous physical games?  Yes  No

List any conditions limiting full participation (physical or emotional)

Any reason for medicines to be taken at camp?  Yes  No

List medicines on back of this form. **For camp, send ample supplies and directions for use.**

Any special equipment such as orthopedic or handicap devices, glasses or contacts, dentures?  Yes  No

What? \_\_\_\_\_

Explain any YES answers on the back of this form and give all information to provide as safe and as full participation as possible.

Immunizations

List each date of last inoculation

Tetanus toxoid \_\_\_\_\_

Polio \_\_\_\_\_

Mumps \_\_\_\_\_

Diphtheria \_\_\_\_\_

Pertussis \_\_\_\_\_

Measles \_\_\_\_\_

Rubella \_\_\_\_\_