

**Four Corners Christian Service Camp**  
 14051 County Road 37 • Mancos, Colorado 81328 • (970) 882-2523

## CAMPER'S HEALTH HISTORY

**FAILURE TO PROVIDE THIS COMPLETED RECORD WITH CAMP REGISTRATION WILL PREVENT THE CAMPER FROM BEING ENROLLED IN THE CAMP.**

|               |             |  |
|---------------|-------------|--|
| Campers Name: | Birth date: | <input type="checkbox"/> Male<br><input type="checkbox"/> Female |
|---------------|-------------|--|

Past history of serious injuries, surgery or illness:

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Allergies, drug (i.e. penicillin) or food reaction:

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List any prescription or over the counter medication which the camper uses. **ALL MEDICATIONS WILL BE KEPT AND ADMINISTERED BY THE CAMP NURSE.**

| MEDICATION | DOSAGE | FREQUENCY | DOCTOR |
|------------|--------|-----------|--------|
|            |        |           |        |
|            |        |           |        |
|            |        |           |        |
|            |        |           |        |

Special Dietary or physical limitations:

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| Separate Form Attached: <input type="checkbox"/> | <p style="text-align: center;"><b>CERTIFICATE OF IMMUNIZATION</b></p> <p>In order to comply with the School Immunization Act, ALL childcare facilities (including camps) must have children's immunization recorded on the Health Department's Certificate of Immunization. For a child coming from another state or country, the parent/guardian may sign the personal exemption section of the form if their child is not "up to date" for Colorado standards. Failure to provide this form will prevent the camper from being enrolled in camp.</p> |
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### AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I, the undersigned parent and/or legal guardian of the camper named above, hereby give my permission to camp officials to call a doctor or emergency medical services to provide emergency medical or surgical care for my child should an emergency arise. I understand that every effort will be made to contact me, or the listed emergency contacts before any action is taken. The camp's insurance will only be responsible for expenses of emergency medical treatment not covered by personal insurance. My personal insurance will be billed first.

|            |       |
|------------|-------|
| Signature: | Date: |
|------------|-------|

### TO BE FILLED OUT ONLY BY PHYSICIAN OR NURSE PRACTITIONER

I, the undersigned, have examined this camper and found him/her to be in satisfactory physical condition, free from any contagious disease and capable of active participation in a regular camp program except as noted.

Exceptions: \_\_\_\_\_

|           |       |      |
|-----------|-------|------|
| Signature | Title | Date |
|-----------|-------|------|

|         |       |
|---------|-------|
| Address | Phone |
|---------|-------|