

Bishop Claggett Center
Health and Information Form with a copy of IMMUNIAZATION Record

Parent or guardian must fill in this form and **return it by the due date indicated on confirmation.**
No participant will be permitted to stay at Claggett without the advance receipt of the completed and signed form. Due 12 days prior to camp or conference or Claggett may replace the participant.
 Please print clearly in ink.

Full Name: _____ Camp or Conference: _____

Date of Birth: _____ Age: _____ Gender: _____

Name of Parent or Guardian: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Home Address: _____ City: _____ State: ___ Zip: _____

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

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name of Personal Physician: _____ Phone: _____

Insurance Information: Carrier: _____ Plan #: _____

Primary Insured: _____ Policy #: _____

Check all items that apply, past or present, to your health history. Explain any yes answers.

ALLERGIES: Food, medicines, insects, plants yes no explain: _____

General Health Information:	YES	NO		YES	NO		YES	NO
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Digestion	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Eyes, Ears, Nose, Throat	<input type="checkbox"/>	<input type="checkbox"/>				Takes Prescriptions Daily	<input type="checkbox"/>	<input type="checkbox"/>

Explain: _____

Check any your child prone to: headaches , Sore Throats , Bed wetting , Sunburn , Poison Ivy , Colds/Fever , Stomach Aches , Sprains , Nightmares , Swimmer's Ear , Menstrual Cramps

List any medications to be taken at camp. _____

List any physical, emotional, or behavioral conditions that may affect or limit full participation in any camp activity: _____

List any special medical equipment needed such as braces, glasses, etc. _____

How would you like us to handle homesickness? _____

Non Prescription Medication

Please check any medication that the health care provider may give your conferee.

Tylenol Advil Benedril Pepto Bismal Sore Throat Spray

Other: _____

Immunizations **NEW REQUIREMENT** according to the State of Maryland

All campers must attach a copy of camper's immunization record. Is camper exempt from immunizations on medical or religious grounds? YES [] NO []

All campers must be current on all immunizations.

Date (month and year) of last tetanus shot: _____
 (Put none if camper has not had a tetanus shot in the past 10 years)

In case of emergency, I understand every effort will be made to contact me. In the event I can not be reached, I hereby give my permission for Bishop Claggett Center, the Center's designee, or the Episcopal Diocese of Maryland to secure proper treatment for the person named on this form, including hospitalization, surgery, anesthesia, or the administration of any medication oral or injected. I agree to be responsible for all costs associated with such treatment.

Date: _____ Signature of Parent or Guardian: _____

Print Full Name of participant : _____

*All medications must be checked in with the health care provider at registration.
 All medications must be in their ORIGINAL containers with the conferee's name and the dosage clearly visible. Medications must be given as per the directions on the prescription container.*

Medication Chart

Medication	Dosage and Time To Be Given						
	Pre-Breakfast	Breakfast	Lunch	Dinner	Night	Other	As Needed
1.							
2.							
3.							
4.							
5.							
6.							
Other Instructions:							

Bishop Claggett Center, P.O. Box 40, Buckeystown, MD 21717
 Phone: 301-874-5147 ext. 100 or 102 FAX: 301-874-0834
 E-mail: info@bishopclaggett.org www.bishopclaggett.org

Updated 3/08