

**Bishop Claggett Center  
Health and Information Form**

Parent or guardian must fill in this form and **return it by the due date indicated on page one of the information packet. No conferee will be permitted to stay at Claggett without the advance receipt of the completed and signed form.** Please print clearly in ink.

Full Name: \_\_\_\_\_ 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: \_\_\_\_\_

over

### Immunizations

**All campers must be current on all immunizations.**

Date (month and year) of last tetanus shot: \_\_\_\_\_

Is conferee currently enrolled in a Maryland Public School? YES  NO . **If answer is no, a copy of the conferee's immunization record must accompany this form.**

Is conferee exempt from immunizations on medical or religious grounds? YES  NO

**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 Conferee: \_\_\_\_\_

*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:							