



Medical History Form

Date: _____

Camper's Last Name: _____ **Camper's First Name:** _____ **M.I.** _____
Camper Birthday MM/DD/YYYY: ___/___/_____

Physician's name: _____ **Physician's Phone:** _____

Health Insurance Company: _____ **Policy #:** _____

MM/YY of Last Tetanus (DPT): ___/___ **Is camper currently enrolled in a MD school? YES/NO**

If Yes, School Name: _____ **If no, provide immunization record or exempt certificate.**

Does your child have any allergies? YES/NO **If Yes, please list and explain severity:**

Does your camper have any dietary restrictions? YES/NO **If Yes, please explain:**

Please list any behavioral or psychological conditions/concerns:

Does your child have Asthma? YES/NO **Does your child carry an inhaler? YES/NO** (If yes please you must fill out the medication form)

Does your camper have an EPI-PEN? YES/ NO **Allergy EPI-PEN is prescribed for:**

Does your camper have medication they will need during camp hours? (If your child is participating in an overnight adventure, please remember to list medications they will need during those hours) YES/NO
(You must fill out a medication form for each each medication the camper will take during camp hours)

Please list any other health concerns or conditions to help us best care for your camper:

Parent Name: _____

Date:

Parent Signature _____

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