

YOUTH HEALTH FORM – CLASS 1
FUN WITH SON PROGRAM
(For ALL Youth Attending Fun With Son Camp)

Name _____ Date of Birth ___/___/___

Parent or Guardian Name _____

Youth Health/Accident Insurance Company _____ Policy # _____

Health Concerns for Youth: Check if youth has or is subject to. Write in any health concerns not listed below.

____ Asthma ____ Fainting Spells ____ Convulsions ____ Heart Trouble ____ Diabetes ____ Blood Disorder

____ ADHD or ADD ____ None of the above applies ____ Other:

____ Allergy to any medication, food, plant, animal or insect toxins (describe, please be specific)

Has Difficulty with: Check if youth has or is subject to

____ Sleepwalking ____ Bedwetting ____ Breathing ____ Eyes, ears, nose, throat ____ Digestion

Any current conditions requiring regular medication? Explain

Any restrictions of activity for medical reasons? Explain:

Are immunizations current according to Minnesota State Laws? Yes ____ No ____ If no explain

Parent Authorization: This health history is correct as I know, and the youth herein described has permission to engage in all prescribed activities, except as noted by me.

Parent/Guardian Signature _____ Date ___/___/___

ADULT HEALTH FORM – CLASS 1
FUN WITH SON PROGRAM
(For ALL Adults Attending Fun With Son Camp)

Name of adult attending camp _____ Age ____ Sex ____

Address if different than child _____

Personal Health/Accident Insurance Company _____ Policy # _____

Health Concerns: Check if you have or are subject to. Write in any concerns not listed below.

____ Asthma ____ Fainting Spells ____ Convulsions ____ Heart Trouble ____ Diabetes

____ Blood Disorder ____ High Blood Pressure ____ None of the above applies ____ Other

____ Allergy to any medication, food, plant, animal or insect toxins (describe, please be specific)

Adult Authorization: This health history is correct as I know, and the person herein described has permission to engage in all activities, except as noted by me.

Adult Signature _____ Date ___/___/___

In case of emergency, I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give permission to the licensed health care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery or injection of medication for my child or for me, if participant is an adult.

Signature _____

In case of emergency contact:

Name _____ Relationship _____ Telephone _____