

# "JUST HORSEIN' AROUND"

## Summer Equestrian Day Camp 2010

850 CR 342 Poteet, TX 78065

Owner/Operator Karen Harris (830)570-9222

[Return to Camp Director](#)

### MEDICAL HISTORY AND PHYSICIAN RELEASE TO PARTICIPATE

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age at Camp \_\_\_\_\_

First Middle Int. Last

Address \_\_\_\_\_  
\_\_\_\_\_

Gender \_\_\_\_\_ Female \_\_\_\_\_ Male

Parent/Legal Guardian Name \_\_\_\_\_

Phone #'s home \_\_\_\_\_ cell \_\_\_\_\_ work \_\_\_\_\_

Emergency Contact other than Parent Name \_\_\_\_\_

Relationship to Parent \_\_\_\_\_

Address \_\_\_\_\_

Phone #'s home \_\_\_\_\_ cell \_\_\_\_\_

Is the camper covered by family medical insurance? Yes \_\_\_\_\_ No \_\_\_\_\_

Health Insurance Provider \_\_\_\_\_ Phone # \_\_\_\_\_

Parent Name: \_\_\_\_\_

## Health History

The following information must be filled out by parent/guardian. The intent of this information is to provide camp personnel the background to provide appropriate care. Please provide up-to-date, accurate information so the camp can be aware of camper's specific needs.

**Allergies** List all know.

Describe reaction & management of the reaction

Medication Allergies

- |    |    |
|----|----|
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |

Food Allergies

- |    |    |
|----|----|
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |

Other Allergies

- |    |    |
|----|----|
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |

**Medication Being Taken routinely:** Please list ALL medications currently being taken, Rx and OTC(over-the-counter).

\_\_\_\_\_ Camper takes NO current medications on a routine basis.

\_\_\_\_\_ Camper takes medications as follows:

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Attach additional information as needed.

**DIETARY Restrictions** List ALL

\_\_\_\_\_  
\_\_\_\_\_

**Explain ANY restrictions to Activities:**

**General Questions: If YES to any , please explain below.**

**NO YES**

1. Any recent injury, illness, surgery?
2. Frequent Headaches?
3. Wears contacts or eyeglasses?
4. Ever had seizures, dizziness or passed out?
5. Ever had joint problems, broken bone(s)?
6. Any major medical condition: asthma, diabetes, etc?
7. Any emotional difficulties in which professional help was sought?

Please explain any "YES" answers:

**The applicant is current on all vaccines? Yes \_\_\_\_\_ No \_\_\_\_\_**

Name of Family Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Preferred choice of Medical Treatment facility \_\_\_\_\_

Name of Family Dentist \_\_\_\_\_ Phone # \_\_\_\_\_

This health history is correct and complete as far s I know. The person herein named has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of medications, and emergency treatment for my child as necessary. It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is a minor. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person herein named.

Signature of Parent/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

## Health Care Recommendations by Licensed Medical Personnel

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

I examined this individual on \_\_\_\_\_

In my opinion, the above individual is \_\_\_\_\_ is not \_\_\_\_\_ able to participate in an active summer camp program.

The applicant is under the care of a physician for the following reasons:

\_\_\_\_\_  
\_\_\_\_\_

Recommendations/ Restrictions at Camp:

\_\_\_\_\_ No recommendations or restrictions at camp.

If Yes, Explain:

\_\_\_\_\_  
\_\_\_\_\_

Signature of Licensed Medical Personnel \_\_\_\_\_

Printed \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_ Date \_\_\_\_\_