THE CLIFFS
CLIMBING + FITNESS

Dates of Camp Attendance _____

The Cliffs History and Emergency Medical Authorization Form
The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. *** Use additional paper if needed.

Camper's Name: Last_____ First_____ Middle_____ Birth Date: _____

Address: Street Address_____ City_____ State_____ Zip_____

Age at camp:_____ Gender: ☐ Female ☐ Male

PARENT/GUARDIAN INFORMATION

Child is in the custodial care of: ☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Other: _____

Custodial Parent/Guardian:_____ Address (if different than child's): _____

Phone 1[Preferred]:_____ Phone 2:_____ E-mail: _____

Parent/Guardian 2:_____ Address (if different than child's): _____

Phone 1[Preferred]:_____ Phone 2:_____ E-mail: _____

EMERGENCY CONTACTS

Name:_____ Relationship:_____ Phone 1:_____ Phone 2:_____ Phone 3: _____

Name:_____ Relationship:_____ Phone 1:_____ Phone 2:_____ Phone 3: _____

HEALTH INFORMATION (Check all that apply and provide requested information)

Allergies	Yes	No	Explain "yes" answers. Include the type of allergy (e.g.- "nut allergy" in the food category)
Animals	☐	☐	
Insect Stings	☐	☐	
Plants/Trees	☐	☐	
Food	☐	☐	
Drugs	☐	☐	
Other	☐	☐	

	Condition	Dates		Condition	Dates		Condition	Dates
☐	ADD/ADHD		☐	Eating Disorder		☐	Mumps	
☐	Arthritis		☐	Epilepsy		☐	Muscle Disease/Disorder	
☐	Asthma		☐	Fainting		☐	Nervous System Disorder	
☐	Athletes Foot		☐	German Measles		☐	Sickle Cell Anemia	
☐	Bed Wetting		☐	Hay Fever		☐	Sinusitis	
☐	Bleeding/Clotting Disorder		☐	Headaches/Migraines		☐	Skeletal Disease/Disorder	
☐	Bronchitis		☐	Hearing		☐	Skin Conditions	
☐	Chicken Pox		☐	Heart Defect/Disease		☐	Sleep Disturbance/Walking	
☐	Colds/Sore Throats		☐	Hypertension		☐	Stomach Upsets	
☐	Constipation		☐	Kidney Disease		☐	Urinary Tract Infections	
☐	Convulsions		☐	Measles		☐	Wear: ☐Contacts ☐Glasses	
☐	Diabetes		☐	Mononucleosis		☐	Other: _____	
☐	Ear Infections		☐	Motion Sickness		☐	Other: _____	

Explain any specific needs or accommodations required: _____

Explain any known behavioral and/or emotional problems: _____

Explain any psychiatric counseling or hospitalization: _____

Explain any operations or serious injuries: _____

Explain any disabilities or chronic or recurring illnesses: _____

Explain any activities that are discouraged or limited by your child's physician: _____

Explain any dietary modifications: _____

If Female, is her menstrual history normal? ☐ Yes ☐ No

Since her last health exam, has your child had:	Yes	No	Explain "yes" answers. Provide details and dates.
A serious injury requiring medical attention?	☐	☐	
An illness lasting longer than one week?	☐	☐	
An in-patient hospital or emergency room treatment?	☐	☐	
Restrictions from participating in any activities?	☐	☐	

Date of Last Health Exam: _____ Current Height: _____ Current Weight: _____

IMMUNIZATION HISTORY -- *[Please attach recent Health Assessment]*

Are all immunizations current? ☐ Yes ☐ No If not, state reason(s): _____ DTP or DT (Tetanus) Date: _____

MEDICATION INFORMATION

Are any prescription medications being taken? ☐ Yes ☐ No Are any of the following used? ☐ Inhaler ☐ EpiPen

Name of Medication	Reason for Medication	Dosage	Frequency

My child may be given: *[Please initial which apply]* _____ ALL listed below

_____ Afterbite _____ Advil (Ibuprofen) _____ Antibiotic cream (Neosportin/Bacitracin) _____ Tylenol (Acetaminophen)

_____ Aspirin _____ Burn Cream _____ Benadryl (Antihistamine)

MEDICAL CARE AND INSURANCE INFORMATION

Physician: _____ Phone: _____ Dentist/Orthodontist: _____ Phone: _____

Preferred Medical Facility: _____ Address: _____

Insurance Company: _____ Policy #: _____ Policy Holder: _____

Company Address: _____ City: _____ State: _____ Zip: _____

AUTHORIZATION FOR MEDICAL CARE

This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child.

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 named above. This completed form may be photocopied for trips out of camp.

Signature: _____ Date: _____

* If for any reason you cannot sign this form, attach a written statement to this form. The statement must be signed for attendance/participation.