

HEALTH UPDATE FORM (bring to camp if any changes since registering)

Name \_\_\_\_\_ Birthdate \_\_\_ / \_\_\_ / \_\_\_ Sex: M / F  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_  
Parent / Guardian Name \_\_\_\_\_ Phone \_\_\_\_\_

Current Medications:

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ When Taken \_\_\_\_\_  
Reason for taking \_\_\_\_\_ Reactions to watch for \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ When Taken \_\_\_\_\_  
Reason for taking \_\_\_\_\_ Reactions to watch for \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ When Taken \_\_\_\_\_  
Reason for taking \_\_\_\_\_ Reactions for watch for \_\_\_\_\_

Most recent tetanus booster: \_\_\_\_\_

New allergies: \_\_\_\_\_

Any other recent illnesses, injuries, or changes in medical condition: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If new MD or insurance company, please complete:

Physician's name \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_  
Insurance Co. \_\_\_\_\_ Subscriber name \_\_\_\_\_ Policy # \_\_\_\_\_