

Person to call if parents(s) cannot be reached (please print clearly):

Name _____ Relationship _____ Phone _____

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Health History

Please check any that apply and describe symptoms of allergy and details of illness or health restrictions on additional sheet.

ALLERGIES

CHRONIC OR RECURRING ILLNESS

___ Hay Fever

___ Ear Infection

___ Drug (specify) _____

___ Hear Disease

___ Insect Stings

___ Convulsions

___ Asthma

___ Diabetes

___ Ivy, Oak

___ Behavior

___ Food (specify) _____

___ Fainting

___ Animals (specify) _____

___ Other (please specify) _____

_____ Date of last Tetanus _____ Date of operations of serious injury _____ Date of illnesses or health restrictions

Does camper attend a Maryland Public School? Yes ___ No ___ If the answer is no, please attach immunization record.

Does camper have any exemptions to required immunizations? Yes/No
If yes, please state reasons and provide addition information

Medications being taken _____

Health Insurance Company _____ Policy number _____

Family physician _____ Phone number _____

**Emergency Authorization: I herby give permission to the Humane Society of Charles County and/or any contact person listed above
authorization for treatment for my child in the even I cannot be reached in an emergency.**

Signature (Parent/Guardian) _____ Date _____