Hungarian Scout Association in Exteris
Külföldi Magyar Cserkészszövetség

Camp Health Form

Troop Number
Csapat Szám

Camp
Tábor

Sándor Sík Scout Camp
5098 Robinson Road, Fillmore, N. Y., 14735
(585) 567-8594 www. sscspark.com

Personal Information All information will be held in strictest confidence in compliance with legislation

Name:_____
(Last) (First) (MI)

Date of Birth:____/____/_____ Age:_____ Male □ Female □
YY/MM/DD

Home Address:_____Apt._____

City:_____ State/Province:_____ Zip:_____ Home Phone:_(___)_____

In Case Of Emergency Contact

Name:_____ Relationship:_____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell/Pager: (____)_____
Address: _____

OR

Name: _____ Relationship: _____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell/Pager: (____)_____
Address: _____

Health Insurance Information

Insurance Company: _____ Health Insurance Number:_____

Insurance Company Claims Address: _____

State/Province:_____ Zip: _____

Insurance Company Phone: (____)_____Name of Policy Holder: _____

Medical Information Attach extra sheet if needed.

Doctor's Name: _____ Phone: (_____)_____

Specialist's Name:_____ Phone: (_____)_____

Are you currently being actively treated for anything? Yes □ No □
If yes, describe the condition(s). Have your doctor list any medications that you are taking on the accompanying form.
List any special instructions that we should know about to ensure your health during camp:

Immunization Record
Note: State law requires that this information be accurate and complete with dates of vaccination. Campers can not stay in camp if this information is incomplete!

YY/MM/DD
Tetanus _____/_____/____Diphtheria ____/_____/____Polio ____/_____/_____ Hepatitis B ___/____/___ Varicella ___/___/____

Measles ____/_____/_____Mumps _____/_____/____ Rubella ___/____/_____ Haemophilus influenza Type B ____/____/____

Allergies

Do you have any allergies to medications? Yes □ No □

Name the medication(s):

_____

Do you have allergies to:	Yes	No	Name/Type	Describe reaction
Insects	□	□	_____	_____
Animals	□	□	_____	_____
Plants	□	□	_____	_____
Foods	□	□	_____	_____
Other	□	□	_____	_____

Medical History

Do you now or have you ever had:	Yes	No	Describe details briefly:
Infectious diseases (Tuberculosis, HIV, Rheumatic fever, etc.)	□	□	_____
Heart conditions (angina, heart attack congestive heart failure, etc.)	□	□	_____
Blood disorders (anemia, clotting problems, bruising, etc.)	□	□	_____
Breathing Problems (asthma, bronchitis, emphysema, etc.)	□	□	_____
Nervous system disorders (fainting, seizures, epilepsy, etc.)	□	□	_____
Mental disorders (depression, schizophrenia, etc.)	□	□	_____
Kidney disease (urinary track infections, stones, dialysis, etc.)	□	□	_____
Digestive problems (ulcers, irritable bowel syndrome, eating disorders,etc.)	□	□	_____
Hormonal disorders (diabetes, thyroid, etc.)	□	□	_____
Are you pregnant (females 11 years and older)?	□	□	_____
Have you been in hospital for anything serious in the last two (2) years?	□	□	_____

Consent for Participation in Water Sports and Activities;

Grant permission to participate : Yes □ No □

Swimming Ability: Non – swimmer □ Beginner □ Intermediate □ Advanced □

Certificate (Type, Given by): _____

Consent to Medical Treatment

To the best of my knowledge, I / the above named camper,am/ is in good health and do/does not suffer from any physical, mental, or emotional problems preventing the participation in camp activities.

In case of medical emergency, permission is hereby granted to the camp first aid staff, physician or healthcare facility designated by the Camp Director to secure proper care and treatment, to hospitalize, order injections, anesthesia or surgery for me/the above named camper.

I release the Hungarian Scout Association, its leaders, helpers and associates, as well as its participants and agents from liabilities and damages incurred by me/my child while participating in all the various scouting activities, or from any liability which may result from medical services pursuant to this waiver.

Signature: _____ Relationship to camper: _____

Name(Printed): _____ Date (YY/ MM/ DD): _____