

**Turtlehead Farm Camp**  
**Medical History & Consent Form**  
*Please email or mail form to address below*

Name of Camper: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age at camp \_\_\_\_\_

Gender \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

**Health Care Providers**

Name of Physician: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Insurance Information**

Is the participant covered by family medical/hospital insurance?

yes \_\_\_\_\_ no \_\_\_\_\_

If so, please indicate the insurance carrier or plan name.

\_\_\_\_\_

**Allergies**

Any medical allergies? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, please list: \_\_\_\_\_

Any food allergies? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, please list: \_\_\_\_\_

Other allergies? (stings, bites, asthma, etc.) Yes \_\_\_\_\_ No \_\_\_\_\_

If so, please list: \_\_\_\_\_

Has your child received vaccinations according to the schedule recommended by the Academy of Pediatrics? Yes \_\_\_\_\_ No \_\_\_\_\_

Date of his/her last Tetanus shot? \_\_\_\_\_

or mark \_\_\_\_\_ **NO** Tetanus (This question must be answered)

## Over the Counter/Prescription Medications

Please list all medications your child will be bringing to camp:

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Please list any over-the-counter medications for treating minor symptoms (cuts, bruises, headaches, sunburn, menstrual cramps, etc.) that your child should not receive.

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If you have a preference for any medications used to treat minor symptoms, please list.

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### THIS BOX MUST BE COMPLETED FOR ATTENDANCE

This health history is correct as far as 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 prescribed medications, and emergency treatment for my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

In the event that I cannot be reached in an emergency, I hereby give permission to the health care provider selected by the camp to secure and administer treatment, including hospitalization for the person named above.

Signature of Parent or Guardian \_\_\_\_\_

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

Please return this form by email or mail.

Email: [info@turtleheadfarm.com](mailto:info@turtleheadfarm.com)

Mail: Turtlehead Farm, 231 Lime Quarry Road, Eastsound, WA 98245