

Remick Country Doctor Museum & Farm  
2010 Vacation Camp Health Form page 2

Emergency Information-

Personal Physician: \_\_\_\_\_

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

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

Health Insurance Company: \_\_\_\_\_

Policy #: \_\_\_\_\_

Health Information

Camper's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Dietary Restrictions: \_\_\_\_\_

Activity Restrictions: \_\_\_\_\_

Allergies to medication/insects: \_\_\_\_\_

Does Camper carry bee sting kit: \_\_\_\_\_

Other Allergies: \_\_\_\_\_

Heart/Respiratory problems: \_\_\_\_\_

Epileptic or history of seizures: \_\_\_\_\_

Is the camper presently taking any medication? \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

**Reminder: This health form and balance of payment are due by February 10, 2010**