

# MEDICAL QUESTIONNAIRE

To be completed and returned to Capital Star Camps

	1 <sup>st</sup> Camper	2 <sup>nd</sup> Camper	3 <sup>rd</sup> Camper
LAST NAME	_____	_____	_____
FIRST NAME	_____	_____	_____
SEX	_____	_____	_____
GRADE	_____	_____	_____
DATE OF BIRTH	_____	_____	_____
AGE	_____	_____	_____

**IN CASE OF EMERGENCY:**

**MOTHER'S NAME AND PHONE** \_\_\_\_\_

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**FATHER'S NAME AND PHONE** \_\_\_\_\_

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**Is there any information concerning your child's health that the nurse should know?**

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**Please indicate any medications or treatments that your child is currently receiving.**

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**Permission to give aspirin?**

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I hereby give permission to the camp director to secure and administer treatment, including hospitalization for the person(s) named above \_\_\_\_\_

Emergency contact name & phone \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_