

# Preschool Health and Insurance Information

## Insurance Information

Is the child covered by family medical/hospital insurance?                      Yes    No  
If so, indicate carrier or plan name: \_\_\_\_\_ Group # \_\_\_\_\_  
Carrier address: \_\_\_\_\_  
Name of insured: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Insurance ID #: \_\_\_\_\_

## Important – This box must be complete for attendance

**Parent/Guardian Authorizations:** This health history is necessary for insurance purposes. I give correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine permission to the physician selected by the health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or including hospitalization, for the person named routine tests. I agree to the release of any records necessary for insurance purposes.

Signature of parent or guardian : \_\_\_\_\_  
Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Allergies

### Medication Allergies (List):

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### Food Allergies (List):

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### Other Allergies (List) – includes things such as asthma, insect stings, etc.

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**Medications Being Taken**

This person **TAKES NO MEDICATION** on a routine basis. **OR** This person **TAKES MEDICATION** as follows:

Med #1: \_\_\_\_\_ Dosage: \_\_\_\_\_ Specific times taken each day: \_\_\_\_\_

Reason for taking: \_\_\_\_\_

Med #2: \_\_\_\_\_ Dosage: \_\_\_\_\_ Specific times taken each day: \_\_\_\_\_

Reason for taking: \_\_\_\_\_

Attach additional pages for more medications.

Identify any medications taken during the school year that child does not/may take during the summer.

**Restrictions (The following restrictions apply to this individual)**

Circle the following that apply:

**Does not eat:** Meat   Dairy Products      Seafood      Eggs    Other (please describe)

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**Explain any restrictions to activity** (e.g. what cannot be done, what adaptations or limitations are necessary)

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**General Health Questions**

**Please fill out to the best of your ability:**

Which of the following has the participant had?

Measels \_\_\_ Chicken Pox \_\_\_ Mumps \_\_\_ German Measles \_\_\_ Hep A \_\_\_ Hep B \_\_\_ Hep C \_\_\_

Is camper current on all immunizations: \_\_\_\_\_ Yes \_\_\_\_\_ No, please explain

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Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

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Name of family physician \_\_\_\_\_ Phone: \_\_\_\_\_

Name of family dentist/orthodontist \_\_\_\_\_ Phone : \_\_\_\_\_