Outpost 2015
Health Information

Required EACH year for EVERY child

Student Info:

First Name: _____ Last Name: _____

Gender: ☐ Male ☐ Female Name prefer to be called: _____

Date of Birth (mm/dd/yy): _____ Grade: _____ Age: _____

Parent/Guardian Contact Info:

☐ Mother ☐ Father ☐ Guardian ☐ Step-parent

First Name: _____

Last Name: _____

Cell Phone: _____

Other Phone: _____

Email: _____

☐ Mother ☐ Father ☐ Guardian ☐ Step-parent

First Name: _____

Last Name: _____

Cell Phone: _____

Other Phone: _____

Email: _____

Health Considerations:

Food allergies? ☐Yes ☐No If yes, list food(s) and reaction(s): _____

_____

_____

Allergic to bee stings? ☐Yes ☐No If yes, describe severity, reactions, and recommended treatment:

_____

_____

Any other allergies? ☐Yes ☐No If yes, describe severity, reactions, and recommended treatment:

_____

_____

Asthma? ☐Yes ☐No If yes, what triggers? ☐Physical Exertion ☐Environment ☐Other _____

What are the symptoms and recommended treatment? _____

_____

Diabetes? ☐Yes ☐No If yes, special instructions? _____

_____

Seizure disorder? ☐Yes ☐No If yes, special instructions? _____

_____

Other: If your student has any mental, emotional or physical handicap(s) which may affect their participation in the Outpost camp, please explain below. Use a separate sheet of paper and attach it to this form, if necessary. This would include activity restrictions, special learning considerations, family circumstances, or other relevant experiences, etc. _____

_____