



Outpost 2016 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 Mother Father Guardian Step-parent
First Name: _____ First Name: _____
Last Name: _____ Last Name: _____
Cell Phone: _____ Cell Phone: _____
Other Phone: _____ Other Phone: _____
Email: _____ 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. _____
