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. ____________________