



MEDICAL INFORMATION

CAMPER NAME _____ CAMP DATES _____

CAMPER ADDRESS _____ DATE _____

CITY/STATE/ZIP _____

MEDICAL HISTORY (To be completed by parents)

- | | |
|---|---------------|
| A. Allergy (drugs, food, asthma, etc.) | Y_____ N_____ |
| B. Pre-Existing injury currently under treatment | Y_____ N_____ |
| C. Medical conditions currently under treatment | Y_____ N_____ |
| D. Birth Deformities (one eye, one kidney, etc.) | Y_____ N_____ |
| E. Fractures or other disability type injuries | Y_____ N_____ |
| F. Mental disorders or convulsion | Y_____ N_____ |
| G. Known past illness for more than one week's duration | Y_____ N_____ |

PLEASE INCLUDE AN EXPLANATION OF ANY QUESTIONS ABOVE ANSWERED
"YES".

PHYSICIAN'S NAME _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

NAME OF DENTIST _____ PHONE _____

MEDICAL INSURANCE _____ POLICY # _____

ADDRESS OF INSURANCE COMPANY _____ PHONE _____

EMERGENCY INFORMATION

Parent or Guardian

(1) _____ PHONE(w) _____

PHONE(h) _____

(2) _____ PHONE(w) _____

PHONE(h) _____

EMERGENCY CONTACT _____

*** Please attach a front and back copy of your child's insurance card to this form.**

*All Saint Louis University Camps and Clinics are open to any and all entrants,
and are only limited by number, age, gender, or grade level.*