

THE AMERICAN BOYCHOIR EXPERIENCE
SUMMER MUSIC CAMP &
CAMP ALBEMARLE
Health Form 2010

SESSION ATTENDING: _____

DATE: _____

NAME: _____ AGE: ____ BIRTHDATE: _____

Last First

ADDRESS: _____

PARENT/GUARDIAN: Do you have medical insurance? _____ If so, please list type of plan, company, and policy number(s): _____

Does this camper have any DRUG ALLERGIES? _____ If yes, please give details -

What drug? What type of reaction? How long ago did reaction occur?

Is this camper allergic to BEE STINGS? _____ If yes, what happens if stung?

MEDICAL HISTORY: Please check the following diseases and/or conditions camper has had and give approximate dates as appropriate.

Chicken Pox _____ Convulsive disorder _____

German Measles _____ Diabetes _____

Measles _____ Strep infection _____

Poliomyelitis _____ Rheumatic Fever _____

Whooping cough _____ Asthma _____

Allergies/hay fever _____

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Does this camper have any other medical conditions which may limit his/her participation in any camp activities or which should be of special concern to the staff? _____ If yes, please explain in detail.

Is this camper receiving psychiatric care or counseling? _____ If yes, please explain.

IMMUNIZATIONS:

Please list dates.

DPT _____ Polio Vaccine _____ Measles _____

_____ Mumps _____ Rubella _____

_____ Other _____

DPT Booster _____

Tuberculin Test: Type _____ Date _____ Result _____

NAME & ADDRESS OF PHYSICIAN:

PHONE _____

SIGNATURE OF PHYSICIAN:

Please return this form with the balance of your tuition by May 15, 2010