

CAMP GLOW 2010 APPLICATION FORM

Applicant Information:

Name of Applicant: _____

Address: _____

Date of Birth: _____

Phone Number (s): _____

Name of Person Completing this Application: _____

Relation to Applicant: _____

Organizational Affiliation: (if any) _____

Session Preference:

_____ Session 1: June 20th through June 25th

_____ Session 2: August 1st through August 6th

_____ Either session is acceptable

Emergency Contact Information:

Name: _____

Address: _____

Telephone: Work _____

Home _____

Cell _____

Name of Primary Physician: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____

Primary insurance: _____ Phone _____

Insured name _____ Group # _____ Policy # _____

HEALTH HISTORY

Last Tetanus _____

ALLERGIES: No Allergies Medication Food Environmental

Please specify: _____

PAST MEDICAL HISTORY: Have you **EVER** had... check all that apply.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Eye Problems/Foreign Body | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Color Blindness | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Ear or Hearing Problems | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Cancer | <input type="checkbox"/> Sports Injuries |
| <input type="checkbox"/> Nutrition Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Radiation/Chemo | <input type="checkbox"/> Muscle Problems |
| <input type="checkbox"/> Nose Problems | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Sprains or Strains |
| <input type="checkbox"/> Mouth/Oral Problems | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Any Prior Work Injury |
| <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Colitis | <input type="checkbox"/> Gout | <input type="checkbox"/> Chiropractic Care |
| <input type="checkbox"/> Lung Infection | <input type="checkbox"/> Urinary Problems | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney/Bladder Infection | <input type="checkbox"/> Hives | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Neurological Problems |
| <input type="checkbox"/> Pacemaker/Stent | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Head/Spine Problems |
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Hernia | <input type="checkbox"/> Prior Back Strains |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Bipolar | <input type="checkbox"/> Ruptured Disc |
| <input type="checkbox"/> Metal in any part of your body | | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Consciousness |

Please explain: _____

Please provide information concerning any dietary restrictions: _____

Please indicate any restrictions related to physical activities, exposure to the sun, etc: _____

Please explain any behavioral concerns: _____

Please explain any mobility or other limitations: _____

Have you had an adverse reaction to: antibiotics adhesive tape aspirin iodine
 Tylenol latex

MEDICATION INFORMATION

DRUG*	STRENGTH	DOSAGE	TIMES GIVEN

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