

MEDICAL HISTORY OF THE CAMPER

2026 Christian Camp for the Deaf

Camper's Name _____

Date of Birth _____

Parent's or Guardian's Name

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell _____ Text _____

Emergency Call _____

Immunization Record: (mark down and give accurate or approximately dates)

Tetanus _____ Polio _____
 Typhoid _____ Measles _____

Previous Illness: (Mark down and give accurate or approximately dates)

Chicken Pox _____ Measles _____ Mumps _____
 Diphtheria _____ Scarlet Fever _____ Whooping Cough _____
 Rheumatic Fever _____ Typhoid Fever _____ Bronchitis _____
 Pneumonia _____ Sinus Infection _____ Ear Infection _____

Is Camper Subject to:

Abdominal Pains _____ Ear Trouble _____ Bed Wetting _____
 Diarrhea _____ Headache _____ Nightmares _____
 Frequent Colds _____ Allergies _____ Sleep Walking _____
 Sore Throat _____ Fainting Spells _____ Temper Tantrums _____
 Constipation (Remedy?) _____ Dizzy Spells _____ Asthma _____

List any medication the camper is currently taking:

Others, remarks and/or special instruction regarding above:

Limitations in camp activities: (e.g., swimming, hiking, athletics, etc.)

