Rockwood Adventures Teen Travel
Camper Health Form

NOTE Your child may not begin the travel program until this form is on file at camp.

Return ASAP, but no later than June1 to:
Rockwood Adventures
Teen Travel
Box 385, Blue Bell, PA 19422

Information on this form is not part of the camper acceptance process, but is gathered to assist us in identifying appropriate care. This form to be completed by parents/guardian of minor.

Name____ Birthdate __________ Sex ________ Age ________
Last Name First Name Middle Initial

Camper Home Address____
Street and Number City State Zip

List the first person you'd like us to call under First Contact.

First Contact ____________________ 1 ☐cell ☐home ☐office 2 ☐cell ☐home ☐office 3 ☐cell ☐home ☐office
Parent/Guardian

Second Contact ____________________ 1 ☐cell ☐home ☐office 2 ☐cell ☐home ☐office 3 ☐cell ☐home ☐office
Parent/Guardian

If above contacts unavailable notify: 1 ☐cell ☐home ☐office 2 ☐cell ☐home ☐office 3 ☐cell ☐home ☐office
Name Relationship

____

Does your child have any chronic or recurring medical conditions? ☐Yes ☐No If Yes, explain________________

____

Name of family physician ______________________________ Phone ______________________

Name of dentist ______________________________ Phone ______________________

Name of orthodontist ______________________________ Phone ______________________

Do you carry medical insurance? ☐Yes ☐No ☐Personal or ☐Work (Company Name) __________________

Carrier: ______________ Policy Number: ________________ Group Number: ________________

Policyholder's Name: ____________________ Mother's Maiden Name: ____________________

FOR FEMALES: Has she menstruated? ________ If not, has she been told about it? ☐Yes ☐No

If her menstrual history is not normal, please explain ______________________________

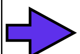
IMPORTANT - THIS BOX MUST BE COMPLETED *

MEDICAL AUTHORIZATION: This health history is correct so far as I know, and the person described has permission to travel throughout the United States and/or Canada and engage in all prescribed camp activities except as noted. Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician/health care facility selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. The completed health forms may be photocopied.

Signature of parent or guardian ______________________________ Date ______________

HIPAA AUTHORIZATION: I hereby authorize any physician, nurse or other heath care provider, to communicate with the director and/or designated staff, of Rockwood Adventures and Sesame/Rockwood Camps / Diamond Ridge Camps, about my child's medical condition, treatment and/or prognosis. I further authorize the director and medical staff to discuss medical condition(s) with the counselors when, in the director's sole discretion, believes such communication to be in the best interest of my child.

Signature of parent or guardian ______________________________ Date ______________



CAMPER MUST SIGN BELOW:
I understand and agree to abide with any restrictions placed on my camp activities and to take my medications if indicated.

Signature of Minor ______________________________ Date ______________

*If for religious reasons you cannot sign this, contact camp for a legal waiver which must be signed for attendance.