



Partner Name

**Camper Information**

First Middle Last Birthdate Gender

**Family Information**

**Personal Information**

Family Role (ex: Mother, Legal Guardian)  
First Name Middle Last  
Email  
Profession

**Primary Address**

Type (ex. Home)  
Street City ST Zip

**Phone**

Phone

**Spouse Information (Optional)**

Family Role (ex: Mother, Legal Guardian)  
First Name Middle Last  
Email  
Profession

**Spouse Primary Address**

Type  
Street City ST Zip

**Spouse Phone**

Phone



**Medical History - Medication Allergies**  No Known Medication Allergies

CAMPER IS ALLERGIC TO AMOXICILLIN	Yes <input type="checkbox"/> No <input type="checkbox"/>	CAMPER IS ALLERGIC TO PENICILLIN	Yes <input type="checkbox"/> No <input type="checkbox"/>
CAMPER IS ALLERGIC TO BACTRIM/SEPTRA/SULFA	Yes <input type="checkbox"/> No <input type="checkbox"/>	CAMPER IS ALLERGIC TO TYLENOL	Yes <input type="checkbox"/> No <input type="checkbox"/>
CAMPER IS ALLERGIC TO IBUPROFEN	Yes <input type="checkbox"/> No <input type="checkbox"/>	CAMPER IS ALLERGIC TO ANOTHER MEDICATION	Yes <input type="checkbox"/> No <input type="checkbox"/>
		IF YES WHAT IS THE MEDICATION	

**Medical History - Allergy History**  No Known Allergies

CAMPER IS ALLERGIC TO INSECT STINGS	Yes <input type="checkbox"/> No <input type="checkbox"/>	CAMPER IS ALLERGIC TO PEANUTS	Yes <input type="checkbox"/> No <input type="checkbox"/>
IF YES SPECIFY INSECT		CAMPER IS ALLERGIC TO EGGS	Yes <input type="checkbox"/> No <input type="checkbox"/>
CAMPER IS ALLERGIC TO POISON IVY, POISON OAK, OR SUMAC	Yes <input type="checkbox"/> No <input type="checkbox"/>	CAMPER IS ALLERGIC TO COW'S MILK	Yes <input type="checkbox"/> No <input type="checkbox"/>
CAMPER IS ALLERGIC TO ANOTHER FOODS	Yes <input type="checkbox"/> No <input type="checkbox"/>	CAMPER IS ALLERGIC TO GLUTEN	Yes <input type="checkbox"/> No <input type="checkbox"/>
IF YES WHAT IS THE FOOD		CAMPER IS ALLERGIC TO SHELLFISH	Yes <input type="checkbox"/> No <input type="checkbox"/>

**Medical History - Health History**  No Known Health Conditions

ASTHMA	Yes <input type="checkbox"/> No <input type="checkbox"/>	SEIZURE DISORDER	Yes <input type="checkbox"/> No <input type="checkbox"/>
ADD / ADHD	Yes <input type="checkbox"/> No <input type="checkbox"/>	HARD OF HEARING/DEAF	Yes <input type="checkbox"/> No <input type="checkbox"/>
HYPOGLYCEMIA	Yes <input type="checkbox"/> No <input type="checkbox"/>	CARDIAC ISSUES / HYPERTENSION	Yes <input type="checkbox"/> No <input type="checkbox"/>
MIGRAINES	Yes <input type="checkbox"/> No <input type="checkbox"/>	BLADDER / KIDNEY	Yes <input type="checkbox"/> No <input type="checkbox"/>
HAS YOUR CAMPER BEEN HOSPITALIZED IN THE LAST YEAR?	Yes <input type="checkbox"/> No <input type="checkbox"/>	SLEEP WALKING	Yes <input type="checkbox"/> No <input type="checkbox"/>
IF YES DETAILS		NIGHT TERRORS	Yes <input type="checkbox"/> No <input type="checkbox"/>
ARE THERE ANY ACTIVITIES YOUR CAMPER IS RESTRICTED FROM DOING?	Yes <input type="checkbox"/> No <input type="checkbox"/>	OTHER CONCERNS/DISORDERS	Yes <input type="checkbox"/> No <input type="checkbox"/>
WHAT ARE THE RESTRICTIONS AND WHY?		IF YES DETAILS	
PHYSICAL DISABILITY (MUSCULAR/COORDINATION)	Yes <input type="checkbox"/> No <input type="checkbox"/>	CAMPER HAS DIABETES	Yes <input type="checkbox"/> No <input type="checkbox"/>
IF YES EXPLAIN		CAMPER BECOMES ILL WHEN EXERCISING IN THE HEAT	Yes <input type="checkbox"/> No <input type="checkbox"/>
CELIAC DISEASE	Yes <input type="checkbox"/> No <input type="checkbox"/>	CAMPER HAS SICKLE CELL ANEMIA	Yes <input type="checkbox"/> No <input type="checkbox"/>
ECZEMA	Yes <input type="checkbox"/> No <input type="checkbox"/>		



**Medical History - Social Concerns**  No Known Social Concerns

DEPRESSION <span style="float:right">Yes <input type="checkbox"/> No <input type="checkbox"/></span>	BI-POLAR / PSYCHO - SOCIAL DISORDER <span style="float:right">Yes <input type="checkbox"/> No <input type="checkbox"/></span>
IF YES EXPLAIN	IF YES EXPLAIN
ANXIETY <span style="float:right">Yes <input type="checkbox"/> No <input type="checkbox"/></span>	
IF YES EXPLAIN	

**Medical History - Emergency Contacts**

Relationship	Contacts Full Name	Daytime Phone	Evening Phone	Cell Phone
Relationship	Contacts Full Name	Daytime Phone	Evening Phone	Cell Phone
Relationship	Contacts Full Name	Daytime Phone	Evening Phone	Cell Phone

**Medical History - Medications**  No Medications Needed

**Medicine will not be dispensed unless the following guidelines are met:**  
 If you are bringing prescription medications they MUST be in the original pharmacy labeled container or the original manufacturer's container.  
 Prescription medications MUST have your attendee's name on the bottle.  
 Any doctor's office samples MUST be accompanied by a signed physician prescription.  
 Please limit the amount of medication to only what is required for your attendee's term.  
 Our Health Center provides most common over the counter medications. Please do not send these to Event Location.  
 If your attendee does not have any medications then you can skip this step and move on to the Next step.

Medication	Route of Administration	Strength	Mark all that Apply	Special Instructions or Comments
			Breakfast <input type="checkbox"/> Dinner <input type="checkbox"/> Lunch <input type="checkbox"/> Bedtime <input type="checkbox"/> As Needed <input type="checkbox"/>	
			Breakfast <input type="checkbox"/> Dinner <input type="checkbox"/> Lunch <input type="checkbox"/> Bedtime <input type="checkbox"/> As Needed <input type="checkbox"/>	
			Breakfast <input type="checkbox"/> Dinner <input type="checkbox"/> Lunch <input type="checkbox"/> Bedtime <input type="checkbox"/> As Needed <input type="checkbox"/>	
			Breakfast <input type="checkbox"/> Dinner <input type="checkbox"/> Lunch <input type="checkbox"/> Bedtime <input type="checkbox"/> As Needed <input type="checkbox"/>	

**Medical History - Insurance**

Name of Insurance Company	Policy Number	Insurance Phone Number
Name of Doctor	Doctors Phone Number	



Medical History - Release

Medical and Liability and Image Release

“The undersigned represents to Vision Atlanta / Camp Grace (herein referred to as VA, a non-profit organization, that he/she is the legal guardian and natural parent or the legal guardian of the above named child; and the undersigned does hereby consent to such minor taking part in the Vision Atlanta Camp Grace, with full understanding that insofar as such activity will involve but is not limited to traveling to and from camp in vans or busses, eating food prepared by camp staff or local restaurants, swimming, horseback riding, camp sports which includes high ropes courses, archery, that there is always the risk of injury, illness, loss, death, and possible consequent expenses for the medical, diagnostic, and curative treatments, and incidental loss and expense, and the undersigned does for him/herself and for and on behalf of such minor assume the risk of such expense and does hereby wholly release VA and any representative from any responsibility or liability; and waives any claims or causes of action against it or its agents that might rise on account of loss, injury, death, or expense occasioned by any sort of accident or any other circumstances involving such child, and agrees to hold harmless in event any such claim should arise; and the undersigned agrees to abide by the rules and regulations, supervision and discipline set applied by VA and its agents, and does hereby authorize VA or its representatives or other agents to arrange for any needed medical treatment or x-rays, and hold harmless VA from any such expenses. The undersigned will reimburse VA fully or furnish payment or insurance for any such payment, at his or her own expense. The undersigned also agrees to pay in full for any property damage caused by his/her own child. Permission is also given to the camp nurse or doctor to administer over the counter medication to the above named child as needed. The undersigned also gives permission to VA to use any image, video or written material that the above named child is in or wrote. Images and videos will be used for the sole purpose of promoting the camp and not for financial gain. The undersigned understand that the directors of VA reserves the right to dismiss any camper (at the urban partner’s expense) who completely disregards the authority set in place at Camp Grace or whose influence and conduct becomes in any way detrimental to the best interests of other participants and staff at Camp Grace.

Parent/Guardian Signature

Date

Additional Questions

Campers Ethnic Background  
African American   
Latino   
Caucasian   
Other

Are Both Parents Living?  
Yes   
No

Camper Lives With?  
Both Parents   
Mother   
Father   
Other