BUCK'S RANCH CAMPS

302 Faith Way
Waynesboro, TN 38485
931-722-7770
www.bucksranchretreat.com

Day Camper Health History

Camper's Name:		Gender:		Age:					
Address:			City:		State:	Zip:			
Parent/	/Guardia Name(s):								
Phone #:		Phone #:							
	ency Contacts:								
1)	Name:								
	Cell Phone #:	none #: H			Home Phone #:				
2)	Name:		_ Relationship to	Camper:					
	Cell Phone #:		_ Home Phone #	:					
3)	Name:		_ Relationship to	Camper:					
	Cell Phone #:		_ Home Phone #	:					
Insurar	nce Information: Please attach a (fro	ont and back) photo	o copy of insuran	ce card to this for	rm.				
Insurance Company:			Policy #	# :					
Address:		Group #:							
Name of Insured:		Policy Holder ID#:							
Name of Primary Physician:		Phone #:							
Name of Dentist:		Phone	Phone #:						
Genera	I Information:								
Is there	e any reason to restrict the camper f	rom any camp activ	vity? YES	NO					
If yes, p	olease explain:								
Does th	ne Camper have any health concern	or special needs?	YES	NO					
If yes, p	olease explain:								
Are all i	immunizations up to date?	YES NO	Date of	last Tetanus shot	:				
Please	list all known allergies (food, medica	tion, other):							
Does th	ne Camper have any dietary restriction	ons? YES	NO						
If ves. r	lease explain:								

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Camper Health History Continued

Camper's Name:				
Does the camper take any medication on a regular basis, either prescribed or over-th			YES	NO
If yes, please explain:				
Do you give the Office permission to give your child Tylenol or Benadryl? Ye	'es	NO		
Use this space to provide any additional information about the camper's behavior a needs the camp should be aware of.	and ph	ysical, emotio	nal, or m	ental health