Estonian Children's Summer Camp Medical Form

Camper's Last Name:		First Name:	Middle Initial:
Date of Birth:	Sex:	Weight:	Blood Type:
Address:			
City:		State:	Zip Code:
Parent's Names: Telephone: Day(___)_____ Evening(___)_____		Primary Insurance Co. Primary Insurance Policy Numbers & Group Name (attach copy of Insurance Card)	
Primary Care Physician: Telephone:			
List any allergies (food, drug, plants, insects etc….)			
List and explain any medical conditions that may require special care or medication: ie; asthma, diabetes, epilepsy, heart disease, special diet			
List any medications that the child is taking, including dosages:			
Is your child prone to anything ie; swimmers ear, earaches, fainting, abdominal pain, headaches, sleep walking, bed wetting?			
Please indicate if there is any over-the-counter medicine you do NOT wish your child to have while at camp:			

IMMUNIZATIONS – Date administered:

(MUST enter date immunization was administered) If disease, put 'D' and year.

Year Last Given:

Tetanus:_____

Diphtheria:_____

Pertussis:_____

Measles:_____

Mumps:_____

Rubella:_____

Polio:_____

Hepatitis B:_____

Varicella (Chicken Pox)_____

Haemophilus Influenza Type B:_____

You may attach a copy of your most recent annual physical as long as it has the dates of your immunizations.