

**CORNERSTONE SUMMER CAMP
2024 CAMPER HEALTH FORM**



Child's Name: _____

Medical History (to be completed by parent or guardian)

1. Does your child have any allergies? yes no
If yes, please provide details and describe severity: _____

2. Is your child on any continuous medication? yes no
If yes, please list the name of the medication(s) and the reason it is being given: _____

3. Has your child ever been hospitalized? yes no
If yes, please list dates and reasons for hospitalization: _____

4. Does your child have any history of:

• diabetes	<input type="checkbox"/> yes	<input type="checkbox"/> no
• convulsions	<input type="checkbox"/> yes	<input type="checkbox"/> no
• heart problems	<input type="checkbox"/> yes	<input type="checkbox"/> no
• significant disease or recurrent illness (please list)	<input type="checkbox"/> yes	<input type="checkbox"/> no
• other conditions (please list)	<input type="checkbox"/> yes	<input type="checkbox"/> no
• _____		

5. Does your child have any mental or physical disabilities? yes no
If yes, please explain: _____

6. If you would like for us to administer non-prescription topical ointments, if needed, during the camp day please indicate below:

First Aid Ointments yes no
(Neosporin Wound Cleanser for Kids, A&D Ointment, Aquaphor)

Bendryl Gel Children's Anti-Itch Cool Gel yes no

Parent/Guardian Signature

Date