

Important: This form must be completed within one year prior to camp and signed by parent or guardian before the child may take part in activities with Future Stars.

Return via - <u>Email: health@fscamps.com</u>

Camper's Name:		Age:	Birthdate: _	Sex: _
Parent 1:		Parent 2:		
Cell Phone: Parent 1		Parent 2		
Home Phone:	Work Phon	ne(s):		
Address:	Work Pho	City.	State:	Zip:
If not available in eme	rgency nlesse notify:			
			Dhono:	
Addraga:		City	I HOHC	7in:
Address		City	State	Zip
Medical Insurance/Me	edicaid Number:			
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Health History/ Is the b	nealth of the camper, in	general good?	Ves	No
	ation History: Please list dat			
mmunizauon/ v accilia	ition instoly. Please list dat	. /		
Diphtheria	Rub		pella CC anus)VID-19
Measles	Dalia	Teta	anus	.ррпсаоте)
Hepatitis B	Varicella (C	Chicken Pox)		
		us Influenza Type B		
	_			
Doctor's Name		Phone No	umber	
Rheumatic Fever	Behavior Problem	Penicillin	Mumps	
Sinus Trouble	Drug Allergies	Hay Fever	Asthma	
Ear Infection	Fainting Spells	Chicken Pox	Other:	
Convulsions	Ivy Poisoning	German Measles	o ther.	
Diabetes	Insect Stings	Measles		
		-	<u> </u>	
Operations or Serious Inju	uries (Dates):			
Other Diseases	ess:			
Other Diseases:				
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Providing an " <u>EPI-PEN"</u> C	OR <u>MEDICATION</u> ? Our "	ound online or we can ema		31 de submitteu.
Please provide any other add	litional information and/or ph			to be aware of
	al or medical conditions, or is			
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Parental Authorization	n			
	ect as far as I know, and the pers	on herein described has nermis	sion to engage in all preso	eribed camp activities
	ng physician and me. In the ever			
physician selected by the camp	director to hospitalize, secure pro			
named above.			_	
Signature			Date	e
	(Must be signed)			