

# GOOD COUNSEL CAMP

## HEALTH CERTIFICATE FOR ADMITTANCE TO ATTEND CAMP SESSION(S) PARENT/GUARDIAN: YOU MUST HAVE YOUR SIGNATURE NOTARIZED

*The camper must have this Certificate completed by the family physician within one (1) year before the opening of camp. After the medical examination, the signed and notarized certificate is to be mailed to the CAMP NURSE, Good Counsel Camp, 8888 E. Gobbler Drive, Floral City, Florida 34436, or you must bring the certificate in person on opening day of camp. No Camper may begin camp unless a completed health form is first received. Every camper is checked by the nurse upon arrival and this health information is mandatory.*

This is to certify that I have examined this day: (Please Print or Type)

Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address \_\_\_\_\_ Hm. Phone (\_\_\_\_) \_\_\_\_\_

*Camper's must be free of any contagious conditions (i.e., lice, scabies, athletes feet, etc.)*

Camper SS# \_\_\_\_\_

Urinalysis \_\_\_\_\_ Neg \_\_\_\_\_ / \_\_\_\_\_ Contagious Disease Contracted: \_\_\_\_\_

Date last tetanus injection \_\_\_\_ / \_\_\_\_ / \_\_\_\_

(To enter Camp everyone must have his/her tetanus injection within the past ten years)

List of allergies (food, drug, plants, insects, etc.) \_\_\_\_\_

Special restrictions and recommendations of Physician (i.e., treatment to be continued, any medication [specific dosages], any medically prescribed meal plan or dietary restrictions): \_\_\_\_\_

I have found (him ) (her ) to be in excellent physical condition and capable of entering all camp activities.

\_\_\_\_\_ Date

\_\_\_\_\_ Physician's Signature

( ) \_\_\_\_\_ Physician's Office Phone

### **PARENT'S/GUARDIAN'S SIGNATURE MUST BE NOTARIZED BELOW IN ORDER FOR CAMPER TO ATTEND CAMP**

*In case of emergency, I understand every effort will be made to contact the parents/guardians of the Camper. In the event I cannot be reached, I hereby give permission to the physician selected by the Camp to hospitalize, secure proper treatment for and to order injections for my child as named above.*

\_\_\_\_\_ Date

\_\_\_\_\_ Signature of Parent/Guardian

( ) \_\_\_\_\_ Emergency Contact / Phone Number

\_\_\_\_\_ Driver's License Number or I.D.

\_\_\_\_\_ Parent's Social Security Number

Insurance Co. Name \_\_\_\_\_

Policy No. \_\_\_\_\_

Sworn and subscribed to me this \_\_\_\_ day of \_\_\_\_\_,

\_\_\_\_\_ Notary Public

Personally known by me \_\_\_\_\_ or provided identification \_\_\_\_\_.

\_\_\_\_\_ Printed

Type of identification \_\_\_\_\_.