

*Camp Maxwellton – Camp Lachlan*  
**Health Medical Record**

**To Be Completed by Parents (please print or type)**

Camper's Full Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
Social Security # \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Parent's Name \_\_\_\_\_ Business Phone \_\_\_\_\_  
Address \_\_\_\_\_ Emergency Phone \_\_\_\_\_

Does Camper wear braces, retainer, headgear, or other orthodontic wear?  If so, please include name and telephone number of orthodontist. \_\_\_\_\_ Phone \_\_\_\_\_

Does camper wear glasses or contact lenses? \_\_\_\_\_

Suggestions from Parents: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Important:** Please notify camp if camper is exposed to any communicable disease during the three weeks prior to arriving at camp.

**Parents Authorization:**

I hereby give permission to the physician selected by the Camp Director to order x-rays, routine tests and treatment for my child. In the event I cannot be reached in an emergency, I give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for and to order injections and/or anesthesia and/ or surgery for my child. I understand that should my child have to be hospitalized, all hospital bills and related doctors will be sent to me or to my family medical insurance carrier for payment.

Date \_\_\_\_\_ Parent's Signature \_\_\_\_\_  
Medical Insurance Carrier \_\_\_\_\_  
Policy Number \_\_\_\_\_

**To Be Completed by Family Physician (please print or type)**

Are Immunizations up to date?  Yes  No\_ If "No" what needs to be monitored? \_\_\_\_\_

Date of last Tetanus Shot \_\_\_\_\_

Allergies (i.e. food, insect bites, poison ivy, etc). \_\_\_\_\_ ( ) No Allergies

How serious are allergies? \_\_\_\_\_ What treatments are administered for allergies? \_\_\_\_\_

Current medications \_\_\_\_\_

Medications brought to camp: Prescription: \_\_\_\_\_ OTC \_\_\_\_\_

Special instructions for medications to be administered at camp: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are there any physical limitations we should be aware of? Please describe: \_\_\_\_\_

\_\_\_\_\_ has been examined by me and has been found fit to take active part in camp activities.  
(name of Camper)

Date \_\_\_\_\_ Signature of Physician \_\_\_\_\_

Physician's Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Phone \_\_\_\_\_

Please return form to: **Camp Maxwellton for Boys or Camp Lachlan for Girls**  
1629 Walkers Creek Road  
Rockbridge Baths, VA 24473

FAX: 540.348.5757  
PHONE: 540.348.5706  
540.348.1090