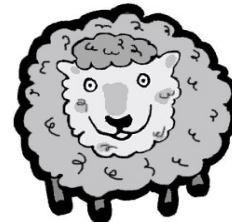


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2019 SHEEP CAMP HEALTH FORM

Due on or before May 1



Please Note: This health form will require a physician's signature, indicating that the child has been examined within the past 2 years and is able to participate in camp activities.

Child's name _____ Sex M F

Date of Birth _____

Address _____

City _____ State _____ Zip _____

Parent/Guardian Name _____

Phone numbers _____
home cell work

Emergency Contacts

Please provide 2 other names other than parents

1. _____
name phone relationship

2. _____
name phone relationship

Child's Physician: _____
name phone number

Health Insurance Company _____

PLEASE INCLUDE A PHOTOCOPY OF THE BACK
AND FRONT OF YOUR INSURANCE CARD WITH THIS FORM

Parent Authorization Statement

"In the event that I am unable to be reached in an emergency, I hereby authorize Caroline and David Owens and/or medical personnel selected by them to take emergency measures as needed. I understand this may include related transportation, x-rays, routine tests, treatment, and release of records as necessary for insurance purposes. The selected physician has my permission to secure and administer treatment, including hospitalization, for my child.

Signature of Parent or Guardian

Date

PLEASE TURN OVER.....

Immunizations

Date of last tetanus vaccination _____

General Information

1. Allergies? Food, medication, insects, plants, etc. ___No ___ Yes (please explain)

2. Does your child have any dietary restrictions? ___No ___ Yes (please explain)

3. Does your child have any restrictions on physical activity? ___No ___ Yes (please explain)

4. Will your child be taking any medication during camp hours 9-3? We do not have a doctor or nurse on site. Therefore, we do not store or dispense medication. If your child does need medication during camp hours, a parent or guardian would need to come and provide it directly. _____

5. Health history:

| | YES | NO | | YES | NO | | YES | NO |
|----------------------|--------------------------|--------------------------|---------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer/Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Convulsions/Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> | ADD/ADHD | <input type="checkbox"/> | <input type="checkbox"/> |

Other medical problems not listed? _____

Please explain any "yes" answers _____

Physician's statement

"I have examined the above child within the past two years. In my opinion, the child is able to participate in an active camp program."

printed physician's name

physician's signature

date