Nevada Youth Range Camp
Health Form

Name of Delegate (*print*): _____

Birthdate: _____ Age: _____ Male ❑ Female ❑

Parent or Guardian Name(s):_____

Home Phone: ( ) _____

Home Address: _____

City/State/Zip: _____

Work Phone: ( ) _____

Primary Emergency Contact Name: _____ Relationship: _____

Phone: ( ) _____

Secondary Emergency Contact Name: _____ Relationship: _____

Phone: ( ) _____

Name of Physician: _____

Phone: ( ) _____

Name of Dentist/Orthodontist: _____

Phone: ( ) _____

Do you have family medical/hospital insurance? Yes ☐ No ☐ If yes, please provide:

Carrier: _____ Policy or Group Number: _____

HEALTH HISTORY	**YES**	**NO**
Frequent Ear Infections	❑	❑
Heart Defect/Disease	❑	❑
Convulsions/Seizures	❑	❑
Diabetes	❑	❑
Bleeding/Clotting Disorders	❑	❑
Nervous or Mental Disorders	❑	❑
ALLERGIES		
Asthma	❑	❑
Hay Fever	❑	❑
Ivy Poisonings, etc.	❑	❑
Insect Stings/Bites	❑	❑

	YES	**NO**
Penicillin	❑	❑
Food Allergies	❑	❑
Other	❑	❑
DISEASES		
Chicken Pox	❑	❑
Measles	❑	❑
German Measles	❑	❑
Mumps	❑	❑
Mononucleosis	❑	❑
Other	❑	❑

If you marked “yes” to any of the above, please explain: _____

_____

Please explain if you are currently taking any prescription drugs: _____

_____

Recent surgical operations, accidents or injuries: _____

_____

Disability or chronic/recurring illness: _____

Special dietary needs: _____

Other conditions we should be aware of: _____

Date of Last Tetanus Booster: _____

_____ _____

Signature of Delegate Date Parent/Guardian Signature Date