



A Good Black Man, Inc.  
 P.O. Box 692  
 Randallstown, MD 21133  
 410-637-5451  
 www.agoodblackman.com

THIS FORM WILL NOT BE SHARED BY ANYONE

**APPLICANT HEALTH RECORD/MEDICAL RELEASE FORM**

THIS FORM MUST BE COMPLETED AND RETURNED BEFORE CAMP ENROLLMENT DATES IN ORDER FOR THE CAMPER TO BE PERMITTED TO PARTICIPATE IN ANY CAMP ACTIVITIES.

**PERSONAL INFORMATION**

new applicant       returning applicant

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ DOB \_\_\_\_\_ Age: \_\_\_\_\_

Person completing application: \_\_\_\_\_ Date: \_\_\_\_\_

**Specify camp child will be attending:**

Location: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Place of employment \_\_\_\_\_ Place of employment \_\_\_\_\_

Health Insurance Carrier \_\_\_\_\_ Policy Number \_\_\_\_\_

Physician's Name \_\_\_\_\_ Is physician authorization needed? \_\_\_\_\_

**In case of emergency, please notify** \_\_\_\_\_

If neither parent nor guardian are available in an emergency, please contact:

1. \_\_\_\_\_ Daytime Phone \_\_\_\_\_

2. \_\_\_\_\_ Daytime Phone \_\_\_\_\_

**HEALTH HISTORY** (Please check approximate allergies, diseases, and conditions listed below).

**DISEASES**

Chicken Pox

Measles

German Measles

Mumps

Asthma

**ALLERGIES**

Hay Fever

Poison Ivy

Insect Stings

Penicillin

Other Drugs

**OTHER**

Ear Infections

Rheumatic Fever

Convulsions

Diabetes \_\_\_\_\_

Concussion \_\_\_\_\_

Behavior \_\_\_\_\_

Special Diet:

\_\_\_\_\_  
 \_\_\_\_\_

---

Please list any past illnesses (contagious and non-Contagious):

---

Please list any operations or serious injuries (include dates):

---

Has camper ever been hospitalized? \_\_\_\_\_ Does camper have any chronic or recurring illness? \_\_\_\_\_

If yes, please list. : \_\_\_\_\_

Is there anything else in camper's health history that the camp staff should know?

---

Are there any activities from which the camper should be restricted?

---

Are there any specific activities that should be encouraged?

---

Will the camper be taking any medication at camp? If yes, please list below:

---

Does the camper wear any medical appliances (glasses, contact lenses, orthodonture, etc.)? If yes, please list:

---

**IF MEDICATION IS REQUIRED, IT MUST COME IN THE ORIGINAL CONTAINER WITH USAGE/DOSAGE/ INSTRUCTIONS CLEARLY PRINTED ON LABEL. A DOCTOR'S NOTE AND PARENTS NOTE MUST ALSO BE SENT.**

---

### **CONSENT FOR MEDICAL TREATMENT**

I do hereby authorize that all of the above information is correct and that my child is fully able to participate in all AGBM LOE Summer Camp activities without need of individual or specialized attention or medical regimen. I agree to notify AGBM, Inc. of any changes in my child's physical or mental health between the dates of enrollment and the start of the camp as well as during camp. I hereby consent and authorize the administration of all medical treatments advisable or necessary under the judgment of the accredited camp trainers, emergency room physicians or any other clinical physicians with the understanding that I will be notified as soon as possible.

Name (please print) \_\_\_\_\_

Relationship to camper: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

---

For internal use only