



## CAMP MEDICAL FORM

Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age at Camp \_\_\_\_\_

Full Mailing Address \_\_\_\_\_

Mom's Name: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_

Dad's Name: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_

### If not available in an emergency,

Name \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

Relationship \_\_\_\_\_

### Medical Insurance Information

Is this participant covered by family medical/hospital insurance? Yes  No

Name of Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

Social Security number of Policy holder or ID number \_\_\_\_\_

Group Number \_\_\_\_\_

### HEALTH HISTORY: This must be completed by the parent / guardian

The intent of this information is to provide the camp health care staff the background to render appropriate care. If there are any changes in the participant's health, prior to camp, the health care staff should be notified upon the participant's arrival at camp.

ALLERGIES: List allergy, describe reaction, and management of the reaction:

Medication Allergies: \_\_\_\_\_

Food Allergies: \_\_\_\_\_

Other Allergies (to include insect stings, hay fever, asthma, animal dander, etc.

Give approximate dates for the following:

Ear, Nose, Throat disorder \_\_\_\_\_

Mononucleosis \_\_\_\_\_

Poison Ivy \_\_\_\_\_

Heart defect/disease \_\_\_\_\_

Convulsions \_\_\_\_\_

Diabetes \_\_\_\_\_

Bleeding/clotting disorders \_\_\_\_\_

Hypertension \_\_\_\_\_

Asthma \_\_\_\_\_

Chicken Pox \_\_\_\_\_

Mumps \_\_\_\_\_

Measles \_\_\_\_\_

German Measles \_\_\_\_\_

HIV/AIDS \_\_\_\_\_

Hepatitis \_\_\_\_\_

Camper Name: \_\_\_\_\_

CHRONIC CONCERNS: Please list, such as asthma, headaches, bedwetting, Diabetes, etc.

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Any other health related information for camp personnel:

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### MEDICATIONS:

1-Please list ALL medications (including over-the-counter or nonprescription medications) taken routinely.

2-Bring enough medication to last the entire time at camp.

3-Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, dosage, and the frequency of administration.

\_\_\_\_\_ This person takes NO medications on a regular basis.

\_\_\_\_\_ This person takes medications as follows, including over-the-counter medications: (Please use separate sheet of paper if needed and attach to this form.)

Name of medication \_\_\_\_\_ Dosage \_\_\_\_\_  
Specific times taken each day \_\_\_\_\_  
Reason for taking this medication \_\_\_\_\_

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Specific times taken each day \_\_\_\_\_  
Reason for taking this medication \_\_\_\_\_

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted.

EMERGENCY AUTHORIZATION: I hereby give permission to the medical personnel selected by the Camp Director to order x-rays, routine tests and treatment for my child, and in the event I cannot be reached in an emergency. I hereby give permission for the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above. This form may be photocopied for use out of camp.

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

Witness \_\_\_\_\_ Date \_\_\_\_\_

I also understand and agree to abide with the restrictions placed on my camp activities.

Signature of Minor \_\_\_\_\_ Date \_\_\_\_\_

Camper Name: \_\_\_\_\_

**Remainder of Medical Form to be completed by a physician, nurse practitioner or physician assistant based on examination done within 1 year of camp attendance.**

Date of Examination \_\_\_\_\_ BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

**RECOMMENDATIONS AND RESTRICTIONS AT CAMP**

Description of prescribed meal plan or dietary restrictions:

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

Description of any physical limitations/restrictions:

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

Additional information for health care staff at camp:

\_\_\_\_\_

**Immunization History: Provide the month and year of the last immunization for:**

Tetanus Booster \_\_\_\_\_ Hepatitis B \_\_\_\_\_ Polio \_\_\_\_\_

MMR \_\_\_\_\_ HIB \_\_\_\_\_ DPT \_\_\_\_\_

Varicella \_\_\_\_\_ Prevnar \_\_\_\_\_

This form must be completed by the physician/nurse practitioner and sent back to camp prior to your child's arrival. Below you will find a list of standard medications we use here at the camp and the standard dosage. Please initial the medications you want used and sign and date below. If you have any additions or corrections please use the lines provided. Thank you.

Tylenol: 325 mg 1 or 2 every 4-6 hours PRN \_\_\_\_\_

Motrin: 200 mg 1 or 2 every 6 hours PRN \_\_\_\_\_

Tums: 2-4 tablets as symptoms occur; may repeat hourly if needed for heartburn \_\_\_\_\_

Maalox: Use as directed on bottle PRN \_\_\_\_\_

Robitussin: Use as directed on bottle and may repeat every 4 hours PRN do not exceed 6 doses in 24 hour period

Neosporin: Clean affected area, apply small amount onto area 1-3 times daily and cover with sterile bandage PRN

Solarcaine/Lidocaine HCL Pain Relief Gel: Fast relief of pain and itch from sunburn, minor burns, cuts, scrapes, and insect bites  
PRN \_\_\_\_\_

Signature of Physician or Nurse Practitioner \_\_\_\_\_

Printed Name \_\_\_\_\_

Address \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

(Office Stamp)

NOTES: