

2010 Spruce Lake Wilderness Camp

Camper Health Form



OFFICE USE ONLY (circle week of camp or expedition)

Camp: DM T1 A1 DW N1 T2 A2 N2 PC Tent # _____

Exp: EB1 EG1 BRT GRT MA WV DC AA EB2

Counselor/ Guide(s): _____

Both sides of this form must be filled out completely and mailed at least 3 weeks prior to the camp week.

Confidential We respect your privacy. This form is intended to provide necessary medical information to care for your child well. It is reviewed by the nursing staff and your child's counselor(s). In the event of an emergency it may also be reviewed by medical personnel, camp administration, office staff, and transportation personnel.

OFFICE USE ONLY: Camper Last Name, First Name

GENERAL CAMPER INFORMATION

Camper Name _____ Gender ___ M ___ F

Age (at camp time) _____ yrs. Birth date: mo. ____/dy. ____/yr. _____

Address _____

City _____ State _____ Zip _____

Camper's Primary Home Phone (_____) _____ - _____

*** Insurance information is required. You may attach a copy of the front and back of insurance card.**

Medical Insurance Carrier _____

Policy # _____ Group # _____

Insurer's Phone (_____) _____ - _____

GUARDIAN / EMERGENCY CONTACT INFORMATION

Parent or Guardian _____

Address _____

City _____ State _____ Zip _____

2nd Parent or Guardian _____

Address _____

City _____ State _____ Zip _____

If above are not available in emergency, notify

Emergency Contact _____

Relationship to camper _____

Additional Phone Numbers for Parent or Guardian:

(_____) _____ - _____

(_____) _____ - _____

Additional Phone Numbers for 2nd parent or Guardian:

(_____) _____ - _____

(_____) _____ - _____

Primary Phone: (_____) _____ - _____

Additional Phone: (_____) _____ - _____

HEALTH CARE PROVIDER INFORMATION

Physician's Name _____

Business Phone (_____) _____ - _____

Date of Last Health Exam*: _____ / _____ / _____.

*We do not require a new Physical exam, as long as it was done within **24 months of camp attendance**. If health exam is not current, further documentation is required. You **must** contact the Wilderness Camp office **prior to 3 weeks** before camp.

Dentist / Orthodontist Name _____

Business Phone (_____) _____ - _____

IMMUNIZATION HISTORY

DO NOT write "current" or "up to date". American Camp Assoc., PA Dept. of Health, and Monroe County require dates (month/year).

You MAY attach a copy of your child's immunization record directly to this form.

Vaccine	Mo./Yr.	Mo./Yr.	Mo./Yr.	Mo./Yr.	Mo./Yr.
DIPHTHERIA AND TETANUS	_____	_____	_____	_____	_____
Toxioids and pertussis (Dtap, DTP, Td, DT, or Tdap) .	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	_____
H. Influenzae	_____	_____	_____	_____	_____
Type b (Hib)	_____	_____	_____	_____	_____
Inactivated Polio	_____	_____	_____	_____	_____
Pneumococcal	_____	_____	_____	_____	_____
Conjugate (PCV, Prevnar) .	_____	_____	_____	_____	_____
Measles-mumps-	_____	_____	_____	_____	_____
Rubella	_____	_____	_____	_____	_____
Varicella (varivax)	_____	_____	_____	_____	_____
(Chicken Pox)	_____	_____	_____	_____	_____

* Last tetanus booster: _____ / _____ / _____

Others if apply to your circumstances:

Hepatitis A _____

Meningococcal _____

Other _____

Last Tuberculosis test _____

(ppd or tine) result _____

* We **must** have date of last tetanus booster! If it has been more than 10 years since receiving a tetanus booster, it must be renewed prior to camp. If immunizations are not practiced by your camper, you **must** contact the Wilderness Camp office **prior to 3 weeks** before camp.

HEALTH HISTORY**CAMPER NAME:** _____**ALLERGIES (indicate severity of all that apply)** **None of the below**

Mild: no medication required (ex: rash resolves on its own)

Moderate: medication **may** be required (ex: Benadryl for hives)Severe: life threatening (ex: carries a bee sting kit) **Required to bring!**

Specify _____ Mild Moderate Severe

Animals _____

Hay Fever _____

Insect Sting _____

Medication _____

Other _____

Elaborate on Allergies, if necessary...

FOOD ALLERGIES & DIETARY RESTRICTIONS **No Food allergies or dietary restrictions**Accommodations can be made for **food allergies, vegetarians, or kosher ONLY**. It is **important** that you contact Spruce Lake Wilderness Camp 3 weeks prior to camp so that we have time to make **necessary arrangements**. If you do have food allergies, we need to know what foods cause what reaction and how dramatic the reaction is. **Please list food restrictions or allergies and any medical interventions necessary (epi-pen, benadryl):****CONDITIONS & DISEASES (check all that apply)** **None of the below**

_____ HIV Positive

_____ Frequent Ear Infections _____ Diabetes

_____ Heart Defects / Disease _____ Hypertension

_____ Convulsions / Epilepsy _____ Mononucleosis

_____ Bleeding / Clotting Disorder _____ Hepatitis

_____ Behavioral _____

_____ ASTHMA _____

_____ Other _____

Elaborate on conditions / diseases. If necessary, clearly indicate if the camper is under a Physician's care for condition and how it **may or may not** affect involvement in camp activities:**Print MEDICATIONS to be given while at camp in the space provided.**

Our camp Physician has authorized Spruce Lake Wilderness Camp to administer common over-the-counter medications as needed.

 My child may take ibuprofen (same as Advil or Motrin) *Check this box if you give permission for us to administer ibuprofen.* **We are providing no additional medications.** *Check this box if applicable otherwise complete below.*NOTE: All medications must be in their original container with original label and given to the Camp Nurse. Do **NOT** send non-prescription medication **unless** they are to be taken on a regular basis.Below signature **required** for Prescription medications only. *Licensed medical personnel is defined as a Medical Doctor, Doctor of Osteopathy, Licensed Nurse Practitioner, or Licensed Physician's Assistant **only**.

Signature of Licensed Medical Personnel* _____ Date _____

Printed Name _____ Title _____

Address _____ Phone (____) _____

<i>Medication</i>	<i>Dosage</i>	<i>Circle Times Needed</i>					
_____	_____	AM	Noon	EVE	BED	As needed	Other _____
_____	_____	AM	Noon	EVE	BED	As needed	Other _____
_____	_____	AM	Noon	EVE	BED	As needed	Other _____
_____	_____	AM	Noon	EVE	BED	As needed	Other _____

Additional limitations or activity restrictions: Indicate below **any** additional limitations of participation, conditions, or instructions, about your son/daughter, that you wish his/her counselor to be aware (use and attach an additional sheet of paper if necessary).

I as the legal guardian of the individual referred to in this document as camper, give permission for the release of medical records in the case of illness/injury. I also give permission to the Camp Nurse, Camp Trip Guides and/or his/her designate to administer the medication as listed on this form, to perform treatment for minor injuries and illnesses, and to perform first aid in the case of more serious injury. Also, I give permission to the Spruce Lake Wilderness Camp Director, Trip Guides and/or designate to allow hospital personnel and/or a licensed physician to perform emergency treatment and administer emergency medications. This authorization shall remain in effect for the duration of the above-mentioned minor's stay.

The information provided in both sides of the Camper Health Form document is true, correct, and complete to the best of my knowledge. I understand that should there be a change in any information in this document, it is my responsibility as parent/guardian to inform Spruce Lake Wilderness Camp of that change.

Parent/Guardian Signature(s) _____ Date: ____ / ____ / ____