2018 Summer Camp
Camper Health Form

OFFICE USE ONLY Day Camp Wilderness Camp
Camp Week(s):

Counselor/ Guide(s): _____ Tent # _____

Both sides of this form must be filled out completely and submitted 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 team and your child's counselor(s). In the event of an emergency it may also be reviewed by medical personnel, camp administration, office team, and transportation personnel.

OFFICE USE ONLY: Camper Last Name, First Name

CAMPER INFORMATION

Camper Full Name _____ Birth date: mo._____/dy._____/yr._____ Age (at camp time)_____

Gender _____ Male ____Female Primary Home Phone (_____) _____ - _____

Camper Home Address _____ City _____ State ____ Zip _____

CONTACT INFORMATION

Parent/Guardian with legal custody to be contacted in case of illness or injury:

Full Name _____ Relationship to Camper _____ Cell Phone (_____)_____-_____

Second parent/guardian or other emergency contact:

Full Name _____ Relationship to Camper _____ Cell Phone (_____)_____-_____

Emergency contacts in event parent(s)/guardian(s) cannot be reached:

Full Name _____ Relationship to Camper _____ Primary Phone (_____)_____-_____

Second emergency contact:

Full Name _____ Relationship to Camper _____ Primary Phone (_____)_____-_____

HEALTH CARE PROVIDERS

Name of camper's primary doctor(s): _____ Phone (_____)_____-_____

Date of Last Health Exam*: month_____/day_____/year_____ *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 Summer Camp office **prior to 3** *weeks* before camp.

Name of dentist(s): _____ Phone (_____)_____-_____

Name of orthodontist(s): _____ Phone (_____)_____-_____

May we contact your child's health care providers? _____ Yes _____ No

MEDICAL INSURANCE INFORMATION

*****Insurance information is required.***

Is your camper covered by health insurance? _____ Yes _____ No Policy Holder's Name _____

Health Insurance ID _____ Policy Holder's Birth Date _____/_____/_____ Relationship _____

Insurance Carrier _____ Carrier's Phone Number (_____)_____-_____

Policy Number _____ Group Number _____ Rx Bin Number _____

Insurer's claims processing address _____ City _____ State _____ Zip _____

Is your camper covered by a prescription plan? ____ Yes ____ No Plan Carrier _____ Plan Number _____

IMMUNIZATIONS

Provide the date of the most recent dose of the tetanus shot. **DO NOT** write "*current*" or "*up to date*". The specific date will be required in the event of an emergency room visit or a serious wound.

*Tetanus Most Recent Dose: _____ / _____ / _____ Comments: _____

*We **must** have the date of the last tetanus booster! If it has been more than 10 years since receiving a booster, it must be renewed prior to camp. Contact us if you do not immunize.

PHYSICAL HEALTH HISTORY

CAMPER NAME:

Please check all that apply. Explain in detail below.

- ❑ **None of the below**
- _____ If Female, Abnormal Menstrual History
- _____ Anorexia, Bulimia
- _____ Back Problems
- _____ Bed Wetting
- _____ Bleeding, Clotting
- _____ Chest Pain, Dizzy, Passing Out
- _____ Diarrhea, Constipation
- _____ Frequent Ear Infections
- _____ Frequent Headaches/Migraines
- _____ Asthma
- _____ Other _____
- _____ Glasses, Contacts, Protective Eyewear
- _____ Head Injury
- _____ Heart Murmur
- _____ High Blood Pressure
- _____ HIV
- _____ Hospitalizations
- _____ Immunodeficiency
- _____ Joint Problems (ankles, knees)
- _____ Knocked Unconscious
- _____ Lice
- _____ **Diabetes***
- _____ Mono (in the last 12 months)
- _____ Orthodontic Appliance
- _____ Recent Infectious Disease
- _____ Recent Injury
- _____ Recurrent/Chronic Illness
- _____ Seizures, Convulsions
- _____ Short of Breath, Wheezing
- _____ Skin Problems
- _____ Sleep Walking
- _____ Surgeries
- _____ Travel Outside of the US

Please explain in detail below. For travel outside the country, please name countries visited and dates of travel. 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:

_____

_____

_____

If your camper has diabetes, you must call Summer Camp to speak with the nurse manager and/or kitchen manager, ESPECIALLY if the camper is unable to count his/her own carbs.

RESTRICTIONS

☐ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.

☐ I have reviewed the program and activities of the camp and feel the camper can participate **with the following restrictions or adaptations:**

Please describe: _____

_____

_____

ALLERGIES – INDICATE THE SEVERITY

Indicate Mild (no medication required), Moderate (medication may be required), Severe (life threatening), or No Allergy. Specify allergen(s).

Animals _____ Hay Fever _____ Insect Sting_____ Medication _____

Other Allergy (Please list any allergies you are aware your child has.) _____

FOOD ALLERGIES & DIETARY RESTRICTIONS

Accommodations can be made for **food allergies, vegetarians, or kosher ONLY**. It is important that you contact Spruce Lake Summer 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 severe the reaction is.

Camper Diet: ☐ This camper eats a regular diet.

☐ This camper eats a regular vegetarian diet.

☐ This camper has special food needs.

Please list food restrictions or allergies and any medical interventions necessary (epi-pen, benadryl). Please also indicate whether the allergy allows for any contact with the food in question (at the same table, in the building, etc.).

_____

_____

_____

OFFICE USE ONLY: Camper Last Name. First Name

CAMPER NAME:

MENTAL. EMOTIONAL. AND SOCIAL HEALTH

Please check all that apply. Explain in detail below.

❑ **None of the below**

_____ Attention Deficit Disorder (ADD or ADHD) _____ Disordered Eating _____ Panic, Anxiety Disorder
_____ Behavioral Issues _____ Learning or Processing Challenge _____ Substance Abuse
_____ Depression _____ Obsessive-Compulsive Disorder _____ Other Issue

Please explain "Yes" answers below. If necessary, clearly indicate if the camper is under a professional's care for condition and how it ***may* or may *not*** affect involvement in camp activities:

_____

_____

_____

❑ **This camper will NOT take any daily medications while attending camp.**

❑ **This camper WILL take the following daily medication(s) while at camp:**

NOTE: All medications must be in their original container with original label and given to the Camp Nurse. **Medications CANNOT be administered if not provided in the original container.** Do **not** send non-prescription medication **unless** they are to be taken on a regular basis.

Name of Medication _____ Dosage _____ Initial Count _____ Start Date _____

End Date _____ Reason for Medication _____ Notes _____

When it is given: ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time _____

Name of Medication 2 _____ Dosage _____ Initial Count _____ Start Date _____

End Date _____ Reason for Medication _____ Notes _____

When it is given: ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time _____

Name of Medication 3 _____ Dosage _____ Initial Count _____ Start Date _____

End Date _____ Reason for Medication _____ Notes _____

When it is given: ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time _____

OVER THE COUNTER MEDICATION

If your camper takes OTC medication on a regular basis, please send it in the original packaging labeled with his/her name.

❑ **My child may take Tylenol or Ibuprofen** (same as Advil or Motrin) ***Check this box if you give permission for us to administer ibuprofen and Tylenol.***

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 designee 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 Summer Camp Director, Trip Guides, and/or designee 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 on all pages 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 Summer Camp of that change.

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

OFFICE USE ONLY: Camper Last Name, First Name _____