2023 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:

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____

____

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.).

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____

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).

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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 ____________