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CAMPER INFORMATION						
Camper Full Name			Birth date: mo	/dy/yr	Age (at	camp time)
Gender MaleFemale	Primary Hom	e Phone ()			
Camper Home Address			City		State	Zip
C ONTACT INFORMATION		Parent/G	Guardian with legal cu	stody to be contacted i	n case of illne	ss or injury:
Full Name				Cell Phone ()	
Second parent/guardian or other emer	mency contact:					
Full Name	Relationship	to Camper		Cell Phone ()	
Emergency contacts in event parent(s						
Full Name	Relationship	to Camper		Primary Phone (_)	
Second emergency contact:						
Full Name	5					
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OFFICE USE ONLY: Camper Last Name, First Name

CAMPER NAME:

Please check all that apply. Explain in detail below.

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

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).

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Insect Sting_____ Medication ____

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

Hay Fever

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	s necessary (epi-pen, benadryl). Please also indicate
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whether the allergy allows for any contact with the food in question (at the same table, in the building, etc.).

affect involvement in camp activities: I This camper will NOT take any daily medications while attending camp. I This camper WILL take the following daily medication(s) while at camp: DTE: All medications must be in their original container. Do not send non-prescription medication unless they are to be taken on a regular basis ministered if not provided in the original container. Do not send non-prescription medication unless they are to be taken on a regular basis me of Medication Dosage initial Count Start Date me of Medication 2 Dosage is given: Breakfast Duch Dinner Bedtime Other time me of Medication 2 Dosage Initial Count Start Date me of Medication 2 Notes me of Medication 3 Dosage Initial Count Start Date d Date Reason for Medication me of Medication Notes me of Medication 3 Dosage I all all count Start Date d Date Reason for Medication me of Medication in a regular basis, please send it in the original packaging labeled with his/her name. Dvert the Counter Medication on a regular basis, please send it i			IPER NAME:	
None of the below	MENTAL. EMOTIONAL. AND SOCIAL	HEALTH		
None of the below	Please check all that apply. Explain in d	etail below		
Behavioral issues Learning or Processing Challenge Obsessive-Compulsive Disorder Other issue obsessive-Compulsive Disorder Other issue ase explain "Ves" answers below. If necessary, clearly indicate if the camper is under a professional's care for condition and how it <i>may</i> or may affect involvement in camp activities: This camper will NOT take any daily medications while attending camp. This camper will NOT take any daily medications while attending camp. This camper will NOT take any daily medications while attending camp. This camper will not take the following daily medications (s) while at camp: DTE: All medications must be in their <u>original container</u> . Do not send non-prescription medication unless they are to be taken on a regular basis me of Medication	_			
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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.