Confidential Medical Information and Release

Camper Name: _____

Gender: _____ Birth Date:_____ Age: _____

Home Address_____

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

Name: _____ Home Phone_____

Relationship to Camper_____ Cell Phone_____

Second parent/guardian or other emergency contact:

Name: _____ Home Phone_____

Relationship to Camper_____ Cell Phone_____

Additional contact in event parent(s)/guardian(s) cannot be reached:

Name: _____ Home Phone_____

Relationship to Camper_____ Cell Phone_____

PRESENT MEDICATIONS

In the space provided below (and on a separate sheet of paper if necessary), please list ALL forms of medication taken by the camper, including prescription and non-prescription (over-the-counter) drugs. Please place these medications in a zip lock bag with the camper's name clearly marked on the bag. All medications (prescription and non-prescription) must be in the original packaging or prescription bottles with dosage instructions and prescribing physician information.

Name of Medication Dosage Specific times taken each day or Taken as needed

1_____ _____ _____

Reason for taking_____

2_____ _____ _____

Reason for taking_____

#3_____ _____ _____

Reason for taking_____

Youth will keep rescue inhalers and/or Epipens unless otherwise noted._____

_____This person takes no medication on a regular basis

The following "Over the Counter" medicines may be given by the nurse if needed: (Please check all that apply)

Acetaminophen_____ Ibuprofen_____ Pepto-Bismol_____ Tums_____

Triple antibiotic lotion (Neosporin)_____ Other(please note reason) _____

Date of last tetanus immunization _____

Allergies: ***(Please describe below what the camper is allergic to and the reaction seen.)***

_____

_____

Diet, Nutrition – special needs or restrictions: ***(Please describe below.)***

_____

_____

List any other health/ wellness needs or restrictions. Please include emotional any mental, emotional or behavioral concerns

_____

_____

Is there any other information that the nurse or other medical providers should know?

_____

Health-Care Providers:

Name of camper's primary doctor(s): _____Phone: _____

Name of Dentist(s): _____ Phone: _____

Name of orthodontist(s): _____ Phone: _____

Medical Insurance Information:
This camper is covered by family medical/hospital insurance:_____
Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company_____ Policy Number_____

Parent/Guardian Authorization for Health Care:
This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all retreat activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian _____

Relationship to Camper: _____