

Health Form for Campers & Staff

The information on this form is not part of the camper or staff acceptance process, but is gathered solely to assist us in identifying appropriate care. Pages 1 through 3 are to be completed **in its entirety** by the camper's parent/guardian or the adult staff member. Page 4 is to be completed and signed by your licensed physician.

Please return to:

Lake Greeley Camp
P.O. Box 219
Attn: Medical Form
Moscow, Pennsylvania 18444

REC. #:

Camper's Name _____ Date of Birth _____ Age at Camp _____
Last First Middle

Social Security Number _____ Gender _____

Address _____

Custodial Parent/Guardian _____ Telephone _____

Address (if different from above) _____

Business Address _____

Second parent or guardian emergency contact _____

Address _____

Business Address _____

CABIN:

If not available in an emergency, notify

Name _____ Relationship _____

Address _____ Phone _____

Insurance Information

In addition to the information below, please attach a photocopy of both the front and back sides of your health insurance card.

Family medical/hospital insurance carrier or plan name _____

Group Number _____

Carrier Address _____

Name of Insured _____ Relationship to Participant _____

Social Security Number of policy holder or Insurance ID number _____

SESSION:

IMPORTANT - THESE BOXES MUST BE COMPLETE FOR ATTENDANCE

PERMISSION TO PROVIDE NECESSARY TREATMENT OR EMERGENCY CARE: I hereby give permission to the medical personnel selected by the camp director to provide routine health care and treatment, to administer prescribed medications, seek emergency medical treatment, order x-rays, routine tests; to release any records necessary for insurance purposes; and to provide necessary related transportation for me/or my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper/staff _____

I hereby give permission to the medical personnel to administer the following over the counter medications if the nurse deems it necessary. Dosages will be administered according to the directions on the bottle unless physician directs otherwise. Headache - Tylenol; Upset Stomach - Pepto Bismol; Diarrhea - Immodium AD; Menstrual Cramps - Ibuprophen; Poison Ivy - Calamine Lotion or CortAid.

Signature of parent or guardian or adult camper/staff _____

CAMPER'S NAME:

I also understand and agree to abide by the restrictions placed on my camp activities.

Signature of minor or adult camper/staff _____ Date _____

Witness _____ Date _____

HEALTH HISTORY

The following information must be completed by the parent/guardian, or adult camper or adult staff member. The intent of this information is to provide camp health care personnel the background to provide the appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to the camp's health care personnel upon the participants arrival in camp. Provide complete information so that the camp may be aware of your needs.

ALLERGIES - List all known.

Medication Allergies (*List*)

Describe how the reaction is managed.

Food Allergies (*List*)

Describe how the reaction is managed.

Other Allergies (*List*)

Describe how the reaction is managed.

include insect stings, hay fever, asthma, animal dander etc.

MEDICATIONS BEING TAKEN

Please list **ALL** medications (including over the counter or non prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and frequency of administration.

- This person takes **NO** medications on a routine basis
 This person takes medications as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #3 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

attach additional pages for additional medications.

Are there any medications taken during the school year that the participant may not or will not take during the summer? _____

If yes, please identify these medications here. _____

attach additional pages for additional medications.

RESTRICTIONS - The following restrictions apply to this individual.

Dietary:

- Does not eat red meat Does not eat eggs Does not eat dairy
 Does not eat pork Does not eat seafood Does not eat poultry
 Other (*describe*) _____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary).

HEALTH CARE RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL

I have examined the aforementioned camp participant. Date of last examination _____

Blood Pressure _____ Weight _____ Height _____

In my opinion, the above applicant is is not able to participate in an active camp program.

The applicant is under the care of the physician for the following conditions

Current treatment at time of this report includes

RECOMMENDATIONS AND RESTRICTIONS AT CAMP

Treatment to be continued at camp

Medications to be administered at camp (name, dosage, frequency)

Any medically-prescribed meal plan or dietary restrictions

Known Allergies

Description of any limitation or restriction on camp activities

Additional information for the health care staff at camp

Signature of Licensed Medical Personnel _____	Date _____
Print Name _____	Title _____
Address _____	Phone _____

FOR CAMP USE ONLY: SCREENING RECORD

Date Screened _____ Time _____ AM
PM

Meds Received _____

Updates/additions to health history noted? YES NO NONE REQUIRED

Current Health Needs Identified _____

Observational Notes _____

Screened by _____