Camp Monakiwa

Health Form

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. This form, except for the "Health Recommendations of Licenses Medical Personnel," to be filled in by parents/guardians of minors or by adults themselves.

Name: ______________________________ Birth Date: ________ Age at Camp: _______

Home Address: ______________________________

Street Address *City* *State* *Zip*

Social Security Number of Participant: _______ - ______ - ________ Gender: ____Male ____ Female

Custodial Parent / Guardian: ______________________________ Phone: ______________

Home Address: ______________________________
(If different from above) *Street Address* *City* *State* *Zip*

Business Address: ______________________________

Street Address *City* *State* *Zip* *Phone*

Second Parent/Guardian/Emergency Contact: ______________________________

Business Address: ______________________________

Street Address *City* *State* *Zip* *Phone*

If not available in an emergency, notify:

Name: ______________________________

Relationship: ______________________________

Address: ______________________________

Street Address *City* *State* *Zip* *Phone*

Insurance Information
Is the participant covered by family medical/hospital insurance? _____ Yes _____ No

If so, indicate carrier or plan name: ______________________________

Carrier Address: ______________________________

Name of insured: ______________________________ Relationship to Participant: ______________

Social Security Number of policy holder or insurance ID number: ______________________________

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 order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me or my child. In the event 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/staffer ______________________________

Witness ______________________________ Date ______________________________

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

Signature of parent or guardian or adult camper/staffer ______________________________

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

Allergies

Describe reaction and management of the reaction. ***Medication, food, insect stings, hay fever, animal dander, etc.***

____

____

____

Restrictions

The following restrictions apply to this individual.

___Does not eat red meat
___Does not eat poultry
___Other: (describe)
___Does not eat pork
___Does not eat seafood
___Does not eat eggs
___Does not eat dairy products

____

____

____

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

____

____

____

General Questions (Explain "yes" answers below)

1. Had any recent injury, illness or infectious disease? yes or no
2. Have a chronic or recurring illness/condition? yes or no
3. Ever been hospitalized? yes or no
4. Ever had surgery? yes or no
5. Have frequent headaches? yes or no
6. Ever had a head injury? yes or no
7. Ever been knocked unconscious? yes or no
8. Wear glasses, contacts, or protective eyewear? yes or no
9. Ever had frequent ear infections? yes or no
10. Ever passed out during or after exercise? yes or no
11. Ever been dizzy during or after exercise? yes or no
12. Ever had seizures? yes or no
13. Ever had chest pain during or after exercise? yes or no
14. Ever had high blood pressure? yes or no
15. Ever been diagnosed with a heart murmur? yes or no
16. Ever had back problems? yes or no
17. Ever had problems with joints? yes or no
18. Orthodontic appliance being brought to camp? yes or no
19. Have any skin problems? yes or no
20. Have diabetes? yes or no
21. Have asthma? yes or no
22. Had mononucleosis in the past 12 months? yes or no
23. Have problems with diarrhea/constipation? yes or no
24. Have problems with sleepwalking? yes or no
25. If female, have an abnormal menstrual history? yes or no
26. Have a history of bed-wetting? yes or no
27. Ever had an eating disorder? yes or no
28. Ever had emotional difficulties for professional help was sought? yes or no

Please explain any "yes" answers, noting the number of the questions.

____

____

____

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Health Care Recommendations by Licensed Medical Personnel

Camper/Staff Member Name: ____

I have examined the above camp participant. Date of last examination: ______________________

BP: ______________ 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 a physician for the following conditions:

____

____

Recommendations and Restrictions at Camp
Treatment to be continued at camp:

____

____

Medications to be administered at camp:
(Found on the chart on the next page)

Any medically prescribed meal plan or dietary restrictions

____

____

Known Allergies

____

____

Description of any limitations or restriction on camp activities

____

____

Additional information for health care staff at the camp

____

____

Signature of Licensed Medical Personnel ______________________________________

Printed Name: ____

Date: ______________________________ Phone Number: ______________________

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Vaccine Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP						
TD (Tetanus/Diptheria)						
Tetanus						
Polio						
MMR						
or Measles						
or Mumps						
or Rubella						
Haemophilus Influenza B						
Hepatitis B						
Varicella (Chicken Pox)						
BCG						

Prescription Medications (Please complete with patient's current regiment for both scheduled and PRN medications.)

Drug	Dosage	Schedule	Comments

Standard Over the Counter/PRN Medications *(meds available in the Infirmary/First Aid Kits, to be administered at the discretion of RN)*

☐ Check here to give permission for the camp to administer the following if deemed necessary. Feel free to cross out any products that you do not want your child to have.

For pain, cough cold
Tylenol or Aleve
Ibuprofen
Benadryl
Chlor-Trimetron
Robitussin
Sudafed
Chloraseptic spray
Cough drops / throat lozenges
Herbal tea

For Digestive Upsets
Tums (or similar antacids)
Pepto Bismol
Altoids or peppermint
Kaopectate
Milk of Magnesia

Topical (skin) Products
Insect Repellent (with DEET)
Chigger Powder (contains sulfur)
Sunscreen
Aloe Vera Plant or Gel
Calamine or Caladryl lotion
Skin moisturizer (Avon Skin So Soft)
1% Hydrocortisone Cream
Antibiotic Ointment
2% Lidocaine Jelly or Spray
Hydrogen Peroxide

To help us determine medication dosages, please provide:

Child's age this summer: _______ Height: _______ Weight: _______ pounds