Due two weeks prior to camp attendance

Mail to:
CSC Registration Office, 9692 Meadowview Dr., Newburg, MD 20664

Do not fax health forms.

FOR OFFICE USE ONLY

REV. 09/16

Name:_____ Last name, First Name

Cabin:_____ Year_____

Camp St. Charles Health Form

(required for camp attendance)

PLEASE ATTACH RECENT PHOTO OF CAMPER TO TOP RIGHT CORNER OF FORM

Name: _____
(camper/staff member)

Date of Birth_____ Age at camp_____

Home Address:_____

_____

Gender: ☐ Male ☐ Female Session:_____

Custodial Parent or Guardian _____

Home Address (if different from above)_____

INCLUDE AREA CODES	Mother/Female guardian	Father/Male guardian
Home phone:		
Business phone:		
Cell phone:		

Emergency contact person (other than parents) : _____

Emergency contact phone number: (_____)_____-_____

Insurance Information:

Is the camper covered by family medical/hospital insurance? ☐ yes ☐ no

If yes, indicate carrier or plan name_____

Group #_____Subscriber name_____

Attach copy of insurance card ☐

Permission to Seek Emergency Medical Treatment: (required for camp attendance)

This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted on this form and discussed with camp director.
I hereby give permission to Camp St. Charles to provide, seek and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

It is my intention that the camp be treated as acting in loco parentis if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability Act of 1996. I hereby agree to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (I) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (II) in the care of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

In the event that I can not be reached in an emergency, I hereby give permission to the physician selected by the camp 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 staff member
Date_____Printed Name_____

If there are restrictions on participation in any camp activity, this area must be signed by the camper or staff member.

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

_____
Signature of minor or adult staff member

Date:_____

DO NOT FAX/SCAN

DO NOT FAX/SCAN

Name:_____

Health History

Allergies (list all known, medication, food and other allergies):

Allergen	Describe Reaction and Treatment needed
_____	_____
_____	_____
_____	_____
_____	_____

**Food Allergies – Please complete our food allergy online form to provide more detailed information to our kitchen staff*

Medications:

Please list all over the counter and/or prescription medications being taken routinely.

Medications are given at 7:30-8am (breakfast), 11:45am-12pm (lunch), 5:30-5:45pm (dinner) and 8:30-9pm (bedtime/showers). Medication will be given at other times if medically necessary.

☐ This person takes NO MEDICATIONS on a routine basis.
☐ This person takes medication as follows:

Med #1_____ Dosage_____
Time taken_____ Reason for taking_____
Med #2_____ Dosage_____
Time taken_____ Reason for taking_____
Med #3_____ Dosage_____
Time taken_____ Reason for taking_____

Attach additional pages for more medications.

Please list any medications taken during the school year that are not taken during the summer:

_____

_____

Permission for use of Common OTC Medications and Topical Sunscreen and Insect Repellent:

The following is a list of common, minor ailments and the medications used to treat them, as contained in the Camp St. Charles medical protocols. **Please make notes about any special concerns about treatment of these or other minor ailments, including allergies, etc.**

Ailment/Symptom	Medication
Headache/Fever	Tylenol/Advil (or generic equivalent)
Upset Stomach	Tums, Pepto (or generic equivalent)
Vomiting	Emetrol, Nausetrol (or generic equivalent)
Minor Allergies	antihistamine, Benadryl, Claritin
Poison Ivy	anti-itch cream
Insect Bites/Stings	antiseptic, anti-itch cream
Insect repellent (may contain DEET)	applied to campers before campout or whenever deemed appropriate by camp director
Diarrhea	Kaopectate (or generic equivalent)
Sunscreen	Campers are expected to provide and apply their own sunscreen; however, in the case of very young and very fair campers, camp staff may assist campers. Camp staff will assist any campers who request assistance with sunscreen.

Dosage for all of the above medications will be as directed on the package.

In the event that my child were to suffer from any of the common ailments listed above, I give permission for the camp nurse to follow the protocol listed above to treat my child's condition. Furthermore, I give permission for Camp staff to apply insect repellent and/or sunscreen when appropriate.

☐ **I hereby permit Camp St. Charles to provide the treatment described above.** Camp St. Charles will honor any special instructions noted on this page.

☐ **I do not grant permission** for Camp St. Charles to administer over the counter medications or topical lotions as described above. This option will require Camp St. Charles medical staff to obtain your verbal permission before treating any non life-threatening emergency, regardless of the date or time of the injury or illness.

_____
Signature of Parent/Guardian

_____ _____
Printed Name of Parent/Guardian Date

DO NOT FAX/SCAN

DO NOT FAX/SCAN

Name:_____

General Health Questions:

Has/does the camper/staff member…

Yes No

- ☐ ☐ 1. Had any recent injury, illness or infectious disease?
- ☐ ☐ 2. Have a chronic or recurring illness/ condition?
- ☐ ☐ 3. Even been hospitalized?
- ☐ ☐ 4. Ever had surgery?
- ☐ ☐ 5. Have frequent headaches?
- ☐ ☐ 6. Ever had a head injury?
- ☐ ☐ 7. Ever been knocked unconscious?
- ☐ ☐ 8. Wear glasses or contacts?
- ☐ ☐ 9. Ever had frequent ear infections?
- ☐ ☐ 10. Ever passed out during or after exercise?
- ☐ ☐ 11. Ever had an asthma attack?
- ☐ ☐ 12. Ever had a seizure?
- ☐ ☐ 13. Ever had chest pain during or after exercise?
- ☐ ☐ 14. Ever had high blood pressure?

Yes No

- ☐ ☐ 15. Ever been diagnosed with a heart murmur?
- ☐ ☐ 16. Ever had back problems?
- ☐ ☐ 17. Ever had problems with joints?
- ☐ ☐ 18. Have an orthodontic appliance being brought to camp?
- ☐ ☐ 19. Have any skin problems(rash, acne)?
- ☐ ☐ 20. Have Diabetes?
- ☐ ☐ 21. Have Asthma?
- ☐ ☐ 22. Had Mononucleosis in the past 12 months?
- ☐ ☐ 23. Had problems with diarrhea/constipation?
- ☐ ☐ 24. Have problems with sleep walking?
- ☐ ☐ 25. If female, have an abnormal menstrual cycle?
- ☐ ☐ 26. Have a history of bed wetting?
- ☐ ☐ 27. Ever had an eating disorder?
- ☐ ☐ 28. Ever had emotional/behavioral problems?

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

_____

_____

_____

_____

IMMUNIZATION INFORMATION:

For campers who reside **within** the United States, a United States territory, or the District of Columbia:

1. State/territory in which child resides:

   _____

2. Is this child exempt from any immunization?
   [ ] NO [ ] YES, list them: _____

   _____

   _____

OR

For campers who reside **outside** the United States, a United States territory, or the District of Columbia:

1. Country in which child resides:

   _____

2. Attach Department form DHMH-896 (record of vaccination or immunity)

Parent, Legal Guardian or
Adult Staff Member's Signature: _____Date: _____

Use this space to provide additional information about the camper/staff member's behavior and physical, emotional, psychiatric or mental health about which the camp should be aware. Contact the camp director prior to camp to discuss any special concerns or needs that your child may have.

_____

_____

_____

_____

Name of Physician _____ Phone:_____
Address_____
Name of Dentist/Orthodonist_____ Phone:_____
Address_____

DO NOT FAX/SCAN

DO NOT FAX/SCAN

Name:_____

Pages 1-3 of the health form should be completed by parent prior to review by licensed medical personnel.

This page must be completed by Licensed Medical Personnel

I examined this individual on _____(date). (Date of exam must be legible and **within 24 months** of camp attendance. Campers or Staff Members with any medical concerns must have an annual exam. **Camp St. Charles highly recommends an annual physical exam for all campers and staff members.**)

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 a physician for the following conditions:

_____

_____

_____

_____

Recommendations and Restrictions at Camp
I have reviewed the medications to be administered at camp. ☐ yes ☐ no
Treatment to be continued at camp and/or other health concerns.

Name of Licensed Medical Personnel _____

Signature of Licensed Medical Personnel _____

Date: _____

Title_____ Phone:_____

Address:_____

_____

_____

FOR CAMP USE ONLY:

Parent/Guardian meeting with Camp Health staff ☐ yes ☐ no _____ initials of camp health staff
Updates/Additions to Health Form Noted ☐ yes ☐ no ☐ none required

Other Notes:_____

_____

_____

_____

_____

_____

DO NOT FAX/SCAN