Due one month prior to camp attendance

Mail to:
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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:_____

FOR OFFICE USE ONLY

REV. 10/08

Name:_____ Last name, First Name Cabin:_____ Year_____

☐ missing parent signature for permission for treatment
☐ missing parent signature for common OTC meds
☐ ☐ missing camper's signature (with restrictions noted)

☐ Missing Dr. signature, exam date or exam notes
☐ ☐ Missing Immunization Record
☐ ☐ Missing Copy of Insurance Card
☐ ☐ Health Concern, needs review by Director/Camp Nurse

Name:_____

Health History

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

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

Medications:

Please list all over the counter and/or prescription medications being taken routinely. All regularly taken (OTC and Rx) pills must be packaged by CampMeds. Inhalers, liquids, nebulizers, "as needed", and injections will be turned into the camp nurse upon arrival at camp. Vitamins and other supplements will only be given at camp if prescribed by a physician and packaged by CampMeds. See CampMeds information sheet and FAQ for details. Contact Camp Director with questions/concerns.

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_____
Med #4_____ Dosage_____
Time taken_____ Reason for taking_____
Med #5_____ 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:

_____

Commonly Used Over the Counter Medications:

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
Diarrhea	Kaopectate (or generic equivalent)

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 the medical staff permission to follow the protocol listed above to treat my child's condition.

☐ I hereby **permit Camp St. Charles to administer** the medications listed above. (Camp St. Charles will follow any special instructions noted on this page.)

☐ I **do not grant permission** for Camp St. Charles to administer any over the counter medications. 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

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 Record

(fill out completely or attach copy of immunization record, DO NOT write "up to date", etc). All campers/minor staff members **must** be current on **all immunizations.** Provide a copy of immunizations confirming that the camper/minor staff member has received all immunizations required by tthe Maryland DHMH recommented Childhood Immunization Schedule. (see *www.EDCP.org* for details) Contact Camp St. Charles for an exemption form if the camper/minor staff member had not be immunized because the immunization was medically contraindicated or for religious reasons.

Vaccine:	***Dates:***	***Mo/Yr***	***Mo/Yr***	***Mo/Yr***	***Mo/Yr***	***Mo/Yr***
DTP	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____	_____
Hepatitus	_____	_____	_____	_____	_____	_____
Varicella (chicken pox)	_____	_____	_____	_____	_____	_____

Which of the following has the camper/staff member had?

☐ measles ☐ chicken pox ☐ german measles ☐ mumps ☐ hepatitis (A, B or C)

Use this space to provide additional information about the camper/staff member's behavior and physical, emotional 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_____

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:_____

_____

_____

_____

_____

_____