Camp St. Charles
REQUIRED HEALTH FORMS
CHECKLIST

Parents, please use this handy checklist to help you organize your child's health information and prepare everything that needs to be mailed to Camp.

HEALTH FORMS ARE DUE ONE MONTH PRIOR TO YOUR CAMPER'S SESSION START DATE.

ALL CAMPERS:

- ◯ Complete **Annual Health Form.**
  (available to complete online in ULTRACAMP or print .pdf version)
  These pages must be completed annually by new and returning campers.
  Print a copy to take to your camper's physical exam.

- ◯ Attach or upload a copy of your current health insurance card, front and back.

- ◯ **PHYSICIAN'S PHYSICAL**
  - Parents may use the Camp St. Charles form or another form with the same information
  - Must be completed and **signed by licensed medical personnel.**
  - Exam date must be present.

- ◯ **Immunization Record** *(ONLY for campers who reside outside of the United States OR who are not enrolled in school OR have not received immunizations required for school attendance.)*

TIME FRAME FOR VALID PHYSICAL EXAMS:

Camper has NO Medical concerns and NO Daily medication:	**Camper takes Daily medication and/or has a medical concern (asthma, etc.)**:
Exam date must be within **24 months** of Camp attendance	Exam date must be within **12 months** of Camp attendance

RETURNING CAMPERS: For campers with medical concerns and no medications, parents may request for us to pull the exam on file from the previous season. Requests must be submitted to the registrar by **May 1st. ALL CAMPERS MUST COMPLETE the annual health form annually.**

HELPFUL HINTS:

- In order to make check-in as efficient as possible and to allow our staff time to review forms, we MUST receive forms in advance.
- Uploaded forms are processed by camp staff and may take up to two weeks to be reflected as complete on your ULTRACAMP account.
- Forms should be submitted one each, no need to submit the forms multiple times, it creates a back log and slows our review process.

Due one month prior to camp attendance

COMPLETE ONLINE
OR
UPLOAD FORMS to camp registration portal

OR

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

FOR OFFICE USE ONLY

REV. 10/22

Year: _____

Cabin: _____

Name: _____ Last Name, First Name

Camp St. Charles Annual Health Form

(Required for Camp Attendance)

Name: _____

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 representative 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 cannot 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

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

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

_____
Signature of minor or adult staff member

_____
Date

Name: _____

Health History

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

Allergen	Describe Reaction and Treatment Needed

***Food Allergies** - Please complete Special Dietary Needs form online on ULTRACAMP 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 or Guardian

_____ _____
Printed Name of Parent or Guardian Date

Name: _____

General Health Questions:

Has/does the camper/staff member...

Yes	No		Yes	No	
☐	☐	1. Had any recent injury, illness or infectious disease?	☐	☐	15. Ever been diagnosed with a heart murmur?
☐	☐	2. Have a chronic or recurring illness/condition?	☐	☐	16. Ever had back problems?
☐	☐	3. Ever been hospitalized?	☐	☐	17. Ever had problems with joints?
☐	☐	4. Ever had surgery?	☐	☐	18. Have an orthodontic appliance being brought to camp?
☐	☐	5. Have frequent headaches?	☐	☐	19. Have any skin problems (rash, acne)?
☐	☐	6. Ever had a head injury?	☐	☐	20. Have Diabetes?
☐	☐	7. Ever been knocked unconscious?	☐	☐	21. Have Asthma?
☐	☐	8. Wear glasses or contacts?	☐	☐	22. Had Mononucleosis in the past 12 months?
☐	☐	9. Ever had frequent ear infections?	☐	☐	23. Had problems with diarrhea/constipation?
☐	☐	10. Ever passed out during or after exercise?	☐	☐	24. Have problems with sleep walking?
☐	☐	11. Ever had an asthma attack?	☐	☐	25. If female, have an abnormal menstrual cycle?
☐	☐	12. Ever had a seizure?	☐	☐	26. Have a history of bed wetting?
☐	☐	13. Ever had chest pain during or after exercise?	☐	☐	27. Ever had an eating disorder?
☐	☐	14. Ever had high blood pressure?	☐	☐	28. Ever had an 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?
☐ Yes ☐ No, 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) or upload immunization record to ULTRACAMP

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 camper 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/Orthodontist: _____ Phone: _____

Address: _____

Name: _____

PHYSICIAN'S PHYSICAL FORM *Required for camp attendance*
Camp St. Charles

Record of a valid physical exam is required for camp attendance. Parent may use a different form in place of this form, if the same information is provided. (exam date, physician's signature, blood pressure, height, weight, medications and general statement of health/eligibility to participate in an active summer program)

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.)**

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: _____

_____

_____

Note any medications typically taken but discontinued at camp: ☐ NONE ☐ LISTED BELOW:

_____

_____

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
☐ None ☐ LISTED BELOW:

_____

_____

_____

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: _____

_____