

CAMP SWATARA HEALTH FORM FOR CAMPERS & STAFF

Name: _____

Date: _____

The information on this form is not part of the staff acceptance process, but is gathered to assist camp in identifying appropriate care. This form is to be filled in by parents/guardians of minors, or by adults themselves.

FORMS MUST BE MAILED TO CAMP AT LEAST ONE-WEEK PRIOR TO WORKING AT CAMP

Name _____ Birth Date _____ Age at Camp _____
Last First Middle

Home address _____
Street address or P O Box City State Zip

Gender: Male / Female

Custodial Parent/Guardian _____ Phones: Home: _____ Cell: _____

Home address _____
(If different from above) Street address or P O Box City State Zip

Business name _____ Business phone: _____

Second parent / guardian / emergency contact
Address _____ Phone: _____
Street address or P O Box City State Zip

Business name _____ Business phone: _____

If the above not available, in an emergency, notify:

Name _____ Relationship _____ Phone: _____

Address: _____
Street address or P O Box City State Zip

IMPORTANT - THE FOLLOWING STATEMENTS MUST BE SIGNED FOR ATTENDANCE

Permission to Provide Necessary Treatment or Emergency Care:

» I hereby give permission to the medical personnel selected by the camp administration to provide routine health care, to administer medications, 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 administration to secure and administer treatment, including hospitalization, for person named above. I also give permission for the camp administration to have access to pertinent medical information.

Signature of parent / guardian or adult camp /staff _____ Date: _____

» I understand and agree to abide by any restrictions placed on my camp activities by licensed medical personnel.

Signature of minor or adult camp /staff _____ Date: _____

» I hereby state that person named above has had a medical examination by licensed medical personnel within the last two years.

Signature of parent / guardian or adult camp /staff _____ Date: _____

A copy of a current medical examination must be provided for any Camper/Staff that has NOT signed the statement above.

INSURANCE INFORMATION - Is the participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name: _____ Group #: _____

Name of insured: _____ Relationship to participant: _____

Insurance ID #: _____ **** PLEASE ATTACH PHOTO COPY OF INS CARD ****

HEALTH HISTORY - The following information must be filled in by the parent/guardian, or Staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival at camp. Provide complete information so that the camp leadership can be aware of your needs.

Name of family physician/medical practice: _____ Phone: _____

Address: _____
Street address or P O Box City State Zip

Please give date of last immunization for tetanus _____ A complete immunization history is available at the office of the above named physician/medical practice. Yes No.

Participants: **Height** _____ **Weight** _____

Allergies - List all known.

Medication Allergies (list)	Describe reaction & management of the reaction
_____	_____
_____	_____

Food and/or Other Allergies (list) - these may include insects, hay fever, asthma, animal dander, etc...

_____	_____
_____	_____

Medication being taken - Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Keep medication in the original packaging that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. ALL medications brought to camp must have the participants name on them.

- This person takes NO prescription medications This person is bringing NO other medications to camp
 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: _____

Restrictions: Explain any restrictions to activity while at camp, any medical concerns, or any behavioral concerns camp should be aware of. What can/cannot be done, what adaptations, corrections, or limitations are necessary or permitted?

