MEDICAL INFORMATION FORM

To insure good health during your child's week of camp, please complete this health form and bring it with you when you register the first day of camp

CAMPER CONTACT INFORMATION

Camper's Name: ________________________________ Birth date: _________________ Home phone: _______________

Parent/Guardian 1:_______________________________ Cell Phone _____________________Work_________________

Parent/Guardian 2: ______________________________ Cell Phone _____________________Work_________________

In case of an emergency, call (if above cannot be reached) ______________________________Phone: ________________

Physician's Name ___________________________________ Physician's Phone ________________________________

INSURANCE INFORMATION

Insurance Information is **REQUIRED** (if you have insurance) since each camper is covered only by limited accident and medical insurance. **You may attach a copy of the front AND back of the insurance card.**

Medical Insurance Carrier______________________________ Phone(______)______-_____________

Policy #____ Group__________________________

Health History:

Date of Last Health Exam: _____/_______/________

Please check all that the camper *has or had in the last year*:

____**Convulsions/Epilepsy***
____**Immune Dysfunction***
____**Heart Defects/Disease***
____**Significant Psychiatric Disorder***
____**Bleeding/Clotting Disorder***
____**Moderate/severe Asthma***
____**Diabetes***
____Mononucleosis
____Ear Infections
____Bedwetting
____Nosebleeds
____Mild Asthma

Other:____

Please explain briefly **all** conditions checked below on Page 2 and how it **may or may not** affect involvement in camp activities:

***These conditions require a MD/PA/ARNP signature that the camper is stable and able to participate fully at camp**

Provider Signature_______________________________

Date__________**Provider phone #**__________________

Allergies: *(Indicate severity of all that apply)*

Mild: No medication required (ex: rash resolves on its own)
Moderate: Medication may be required (ex: Benadryl for hives)
Severe: Life threatening (ex: Epipen for anaphylaxis)

	Specify	Mild	Moderate	Severe
Food				
Animals				
Hay Fever				
Insect Sting				
Medication				
Seasonal				
Other				

Please explain Allergy reaction and details:

****If your camper has food allergies, notify camp at least 1 week prior to the start of your camper's session.****

Date of last tetanus booster: ___/___/____

(over)

Camper Medication:

______ My child has **no** regular medication to take at camp.
______ My child **has** medicine (Prescription or OTC) to be administered while at camp (List Below)

Camper Medications: record medication to be given while at camp in the space provided:

Medication	*Dosage*	*AM*	*Noon*	*PM*	*Evening*	*Bed*	*As Needed*	*Other*	*Reason for taking*

Has the Camper ever been prescribed an EPI PEN? YES NO *If yes, the EPI PEN **must** accompany the camper to camp!*

Please send medication in **ORIGINAL CONTAINER.** Otherwise we **cannot** accept it

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. **Cross out those the camper should NOT be given.**

Ibuprofen (Advil, Motrin) or Naproxen (Aleve)
Diphenhydramine (Benadryl) or nondrowsy antihistamine
Dextromethorphan cough syrup (Robitussin DM)
Acetaminophen (Tylenol)
Calamine lotion
Lice shampoo or cream
Generic Cough Drops
Tums
Antibiotic cream
Aloe Gel
Burn cream
Deet repellant

Please list any additional limitations, conditions, or instructions, about your child, you wish their counselor to be aware of:

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This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program staff about my child's health status.
I give permission for the camp health personnel to administer the medication as listed on this form, to perform treatment for minor injuries and illnesses, and to perform first aid in the case of more serious injury.

Custodial Parent/Guardian Name (Printed) ________________________________ Relationship to camper ___________________

Signature of custodial Parent/Guardian ____Date ___________________________

Confidential: *We respect your privacy. This form is intended to provide necessary medical information. It is reviewed by the health and administrative staff, and your child's counselor(s). In the event of an emergency it may also be reviewed by non-Bethany Birches medical personnel and transportation personnel.*

Updated March, 2021