2020 Medical Information and Release Form

Camp Attending: _____

Camper Information

Campers Name: _____ Dates Attending Camp: _____

Age on Arrival of Camp: _____ Gender: M F Birth date: _____

Address: _____

City: _____ State: _____ Zip: _____ Primary Phone (___)_____

Insurance Company: _____ Policy Number: _____ Name of

Insured: _____ Is camper covered by family insurance? Y N Insurance

Company Phone Number: (___)_____

Camper's Physician: _____ Phone: (___)_____

Include copy of insurance card; copy both sides of the card so information is readable

Emergency Contacts

Parent/ Guardian: _____	Additional Emergency Contact: _____
Relationship to Camper: _____	Relationship to Camper: _____
Preferred Phone: (___)_____	Preferred Phone: (___)_____
Email: _____	Email: _____

General Health Information

Has/ does the camper:			
1. Ever been hospitalized?	Y N	11. Had fainting or dizziness?	Y N
2. Ever had surgery?	Y N	12. Passed out/ had chest pain during exercise?	Y N
3. Have recurrent/ chronic illness?	Y N	13. Had mononucleosis ("mono") during the last 12 months?	Y N
4. Had a recent infectious disease?	Y N	14. If female, have problems with period/ menstruation?	Y N
5. Had a recent injury?	Y N	15. Have problems with falling asleep/ sleepwalking?	Y N Y N
6. Had asthma/ wheezing/ shortness of breath?	Y N	16. Ever had back/joint problems?	Y N
7. Have diabetes?	Y N	17. Have a history/ current bedwetting?	Y N
8. Had seizures?	Y N	18. Have problems with diarrhea/ constipation?	Y N
9. Had headaches?	Y N	19. Have any skin problems?	Y N
10. Wear glasses, contacts, or protective eyewear?	Y N	20. Traveled outside the country in the past 9 months	Y N

Comments:

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Camper Name: _____ Camp Dates: _____

Immunizations

Provide the month and year for each immunization. Starred (*) immunizations must be current.
Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunizations	Dose 1 Month /Year	Dose 2 Month/ Year	Dose 3 Month/ Year	Dose 4 Month/Year	Dose 5 Month/ Year	Most Recent Dose Month/Year
Diptheria, tetanus, perusis * (DTaP) or (TdaP)						
Tetanus booster * (dT) or (TdaP)						
Mumps, measles, rubella * (MMR)						
Pollo * (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis A						
Hepatitis B						
Varicella (chicken pox)						
Had chicken pox? Y N Date:						
Meningococcal meningitis (MCV4)						
Tuberculosis (TB) Test	Date:		Negative		Positive	

Date of most recent physical medical exam: (we recommend having one each year) _____

If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

Signature of custodial parent/ guardian: _____ Date: _____

Relationship to Camper: _____

Allergies (Check all that apply)

No known allergies	Medication	Insect Stings	Food	Other

Please describe below what the camper is allergic to and the reaction seen.

_____
_____
_____

Medication

_____ My child will NOT be bringing any medication to camp.
_____My child will be bringing the following medication(s) to camp:

Medication must be in its original container labeled with the child's name.

Medication	Dose:	Time:	How it is given:	Reason for Taking Medication:

Please provide enough of each medication to last the entire time the camper will be at camp.

Camper Name: _____ Camp Dates: _____

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Mental, Emotional, and Social Health

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/ hyperactivity disorder (AD/HD)?
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?
3. During the past 12 months, seen a professional to address mental/ emotional health concerns?
4. Had a significant life event that continues to affect the camper's life?
(History of abuse, death of a loved one, family change, adoption foster care, new sibling, survived a disaster, divorce, others)

Please explain "Yes" answers in the space below, noting the number of the questions.

_____
_____
_____

Questions

1. Does your camper know any other campers this week? _____

2. What do you hope for your camper during their camp experience at Calvin Center?

_____

3. What other information would be helpful from Calvin Center?

_____

4. Is your camper celebrating a birthday during their stay at Calvin Center? Y N

5. Does your camper have any special dietary needs? (Vegetarian, allergies, etc.) Y N

_____
_____
_____

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 "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's staff about my child's health status.

Signature of Custodial parent/ guardian _____ Date: _____

Relationship to camper _____