

CAMP HOPE CAMPER/UNDER 18 MEDICAL FORM / PERMISSION TO TREAT

I. Camper Information

Camper Legal last and first name _____ SSN _____

DOB _____ Age _____ Please Check Male ___ Female ___ Grade finished as of June this year _____

Home Address: Street _____ City _____

State _____ Zip Code _____ Home phone (_____) _____ - _____

Parent(s)/Guardian Name _____

1. Parent Cell/work phone _____

2. Parent Cell/Work phone _____

Address if different from above _____

II. Emergency Contacts in Event Parent Unavailable (2 contacts mandatory)

1. Name/Relationship to Camper _____

Home/Cell/work numbers _____

2. Name/Relationship to Camper _____

Home/Cell/work numbers _____

III. Insurance Information

Medical Insurance Company _____ Subscriber _____

ID Number _____ *MANDATORY - Attach a copy of both sides of card

PHYSICIAN NAME _____ Phone Number (_____) _____ - _____

Additional Physician Name _____ Phone Number (_____) _____ - _____

ALLERGY INFORMATION: List any allergies to foods, meds, animals, insects, plants or other

For severe Allergies, Asthma, Diabetes or any health issue requiring a nurse's care, you MUST provide a mandatory doctor prescribed protocol AND signature

IV. Offsite Medical Permission

I (give /do not give) permission for my son/daughter, _____, to leave Camp Hope with Camp Hope Staff Members should the opportunity for an offsite trip be made available.

I give permission for my child to receive over the counter cold/cough medication and pain relievers if needed, to be given by a Camp Hope Staff member while off site. Yes ___ No ___

I give the Camp Hope Staff member permission to allow my child to receive emergency medical care if needed. This includes but is not limited to COVID testing if deemed appropriate. Yes ___ No ___

V. Medical Information

A. History: (Check if Yes)

- | | | |
|---|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Menstrual problem | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Glasses | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Stomach/Bowel problem | <input type="checkbox"/> Contacts | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Speech problem | <input type="checkbox"/> Vision problem | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Lung disease/condition | <input type="checkbox"/> Kidney/Bladder problems | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hearing Difficulty | <input type="checkbox"/> Orthopedic problems | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Nasal/Sinus problem | <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injury |

*IF YOU CHECK YES FOR ANY ABOVE ITEMS PLEASE PROVIDE A WRITTEN EXPLANATION IN FULL

Social/psychological (ADD, learning disability, anxiety, depression, etc.)

EXPLAIN: _____

Behavioral Issue

EXPLAIN: _____

Surgical /serious illness /or injury within the last year

EXPLAIN: _____

Physical Limitation or Other

EXPLAIN: _____

• Can your child participate in all activities: YES NO IF NO EXPLAIN: _____

• Please list and explain any general health issue(s) that require ongoing care/nurse's care

• Height _____ Weight _____ Date of last tetanus shot _____ (mandatory)

• Dietary restrictions or concerns (please be specific with severe allergies and dietary needs)

List any medications regularly used:

B. I CERTIFY MY CHILD IS UP TO DATE WITH SCHOOL IMMUNIZATIONS YES NO

• If you selected no, please explain: _____

• Foreign campers/staff must submit full immunization record and current TB test results)

• Have your child received a COVID19 Vaccination? YES NO If YES, date of final shot _____

C. A Physician's Signature of Authorization that this child is in good health to attend camp is required

PHYSICIAN SIGNATURE _____ **Date** _____

AUTHORIZATION: (Parents read all information and sign) I, the parent, have fully, accurately, and to the best of my knowledge completed this history. I understand this information will be shared only on a medical/camp need-to-know basis. I understand a sick/contagious child may not come to camp. I authorize the Camp Nurses to administer medications and treatments if needed by my child, according to Camp Hope Standing Orders or a local Camp Doctor. I hold the Camp Staff harmless in connection with the administration of medications and treatments. In the event of an emergency, I hereby give permission to the Camp Staff to secure treatments and emergency care for my child. I understand I am financially responsible for any/all medical bills/copays incurred, including payments incurred not covered by my insurance. I have attached a copy, front and back, of my child's insurance card.

Printed Name of Parent/Guardian/Individual (over 18)

PARENT SIGNATURE _____ **Date** _____

CAMP HOPE MEDICATION USE & PERMISSION FORM

PLEASE FILL OUT ONE FORM PER INDIVIDUAL ATTENDING CAMP HOPE

FOR CAMPER / COUNSELORS under 18 – This Form must be completed by a Parent and Doctor for any camper/counselor taking any medications of any kind - (prescriptions, over-the-counter, vitamins, herbals). Individuals under 18 years of age taking routine medications MUST have a signed permission for administration from both the physician and the parent.

FOR COUNSELORS / STAFF 18+ – This Form must be completed by any individual (18+) taking any medications of any kind. (prescriptions, over-the-counter, vitamins, herbals)

LAST NAME _____ FIRST NAME _____ DATE _____

Medications for any individual will be administered by nurses at Camp Hope.

- If a child must carry an emergency medication such as an inhaler or Epi-pen, the doctor must provide specific permission/instructions for carrying and self-administering medication at camp.
- All meds and permission forms will be handed to nurse upon arrival at Camp Hope. Please plan to review administration with nurse and your child.
- Prescription drugs must be in original bottle, with date for this year and labeled for the specific child. Label every prescription box/non-prescription container/equipment with child's name.
- Package all medications for each child in a large Ziploc bag and label with child's name.

MEDICATION	DOSE	FREQUENCY	REASON FOR MEDICATION

I hereby authorize this individual / child to receive the above medications while at Camp Hope.

Individual (if 18+) Name: _____ Individual Signature: _____

Parent and Doctor sign below for any camper / counselor under 18.

Parent/Guardian Name: _____ Parent Signature: _____

Physician Name: _____ Physician Signature: _____