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

I. Camper Information

Camper Legal last and first name ____

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)

___ Allergies
___ Sleepwalking
___ Stomach/Bowel problem
___ Speech problem
___ Lung disease/condition
___ Hearing Difficulty
___ Nasal/Sinus problem
___ Menstrual problem
___ Glasses
___ Contacts
___ Vision problem
___ Kidney/Bladder problems
___ Orthopedic problems
___ Asthma
___ Bedwetting
___ Diabetes
___ Eating Disorder
___ Fainting
___ Heart Disease
___ Hypertension
___ Head Injury

*IF YOU CHECK YES FOR ANY ABOVE ITEMS PLEASE PROVIDE A WRITTEN EXPLANTION 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)*
- Has 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 CAMPERS / 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: _________________________