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 permission for my son/daughter, _____, to leave Camp Hope with Camp Hope Staff Members should the opportunity for an offsite trip be made available. **Yes ___ No ___**

• 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 permission for my child to receive emergency medical care if needed. **Yes ___ No ___**

V. Medical Information

A. History: (Check if Yes)

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

*IF YOU CHECK 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)*

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 Name (18+):_____ Individual Signature: _____

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

Parent/Guardian Name:_____ Parent Signature: _____

Physician Name: _____ Physician Signature: _____