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. Permissions

• 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 the camp nursing staff on site and a camp staff member if 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

IMPORTANT NOTICES

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

PLEASE FILL OUT ONE FORM PER INDIVIDUAL ATTENDING CAMP HOPE

FOR CAMPERS / COUNSELORS under 18 – This form MUST be completed by both a parent and doctor for any camper/counselor under 18 taking prescribed medications of any kind.

FOR COUNSELORS / STAFF 18+ – This form must be completed by any individual (18+) taking medications of any kind both regularly or as needed.

LAST NAME_____FIRST NAME_____DATE_____

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 / volunteer under 18.

Parent/Guardian Name:_____ Parent Signature: _____

Physician Name: _____ Physician Signature: _____