CAMPER HEALTH FORM Session_____ Tent_____

CAMPER LAST NAME FIRST NAME MIDDLE INITIAL DATE OF BIRTH (MM/DD/YYYY)

HOME ADDRESS CITY STATE ZIP CODE HOME PHONE #

MOM'S NAME MOM'S CELL PHONE MOM'S WORK PHONE OTHER PHONE

DAD'S NAME DAD'S CELL PHONE DAD'S WORK PHONE OTHER PHONE

IF NOT AVAILABLE IN AN EMERGENCY, PLEASE NOTIFY:

1. NAME: ___________________________________ RELATIONSHIP TO CHILD:_____________________

PHONE#: ________________________ CELL#: _____________________ WORK#:____________________

2. NAME: ___________________________________ RELATIONSHIP TO CHILD:______________________

PHONE#: ________________________ CELL#: _____________________ WORK#:____________________

ALLERGIES: Please list any allergies to medications, foods, insect stings or environmental stimuli. PLEASE describe the reaction your child has when exposed to these allergens. Make special note of any anaphylactic reactions—those that require an EPI Pen.

MEDICATIONS: Please list all medications that your child will be taking while at camp.

Medication	Dose	Frequency (circle)		Time(s) to be given (circle)		
______________________	________________	Daily	As Needed	Breakfast	Dinner	Bedtime
______________________	________________	Daily	As Needed	Breakfast	Dinner	Bedtime
______________________	________________	Daily	As Needed	Breakfast	Dinner	Bedtime
______________________	________________	Daily	As Needed	Breakfast	Dinner	Bedtime
______________________	________________	Daily	As Needed	Breakfast	Dinner	Bedtime

CHRONIC HEALTH STATES—Please check all that apply. Describe below or attach a separate note to describe any condition that requires special attention by the camp nurse. This information will be shared with appropriate staff members.

- ❑ This camper has no chronic health concerns.
- ❑ This camper has the following chronic health concerns:
  - ❑ Headaches
  - ❑ Seizure Condition
  - ❑ Heart Murmur
  - ❑ Diabetes
  - ❑ Bedwetting
  - ❑ Asthma (attach action plan)
  - ❑ Sleepwalking
  - ❑ Frequent Colds / Infections
  - ❑ Lactose Intolerance
  - ❑ Knee, Ankle or Back problems
  - ❑ Eczema / Hives or Other Skin Conditions
  - ❑ Other (Please describe below)

Camper name ____________________________ **Session**________ **Tent**________

OVER-THE-COUNTER MEDICATIONS—Camp stocks many over-the-counter (OTC) medications in tablet, chewable and liquid form. You do not need to send OTC meds to camp. Unless specifically indicated, we will administer OTC meds from our stock**. If there are any OTC medications that your child absolutely should not have**, for example, due to allergy or prescription drug interaction, please list those medications below:

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PRIMARY HEALTH CARE PROVIDERS—Please provide the names and phone numbers of your home physicians.

Pediatrician ____ Phone______________________________

Orthodontist ____ Phone______________________________

Dentist ____ Phone ______________________________

Mental Health Provider ___________________________________ _ Phone ______________________________

WHAT HAVE WE FORGOTTEN TO ASK? Please provide any additional information about your child's health, which may not have been discussed on this form. Attach another sheet if necessary.

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IMMUNIZATION HISTORY—Please provide the month and year for each immunization or check box below.

❑ **Immunization record is up to date and on file at school. School name:** ____________________________

Immunization	Dose 1	Dose 2	Dose 3	Dose4
Diphtheria, Tetanus, Pertussis - DTP				
Booster: Tetanus, Diphtheria, Acellular Pertussis - Tdap		Must be current within last 5 yrs		
Meningococcal Vaccine (when recommended by your Dr)		Usually given at 11-12 yrs		
Measles, Mumps, Rubella – MMR 2 doses required for camp				
Pneumococcal Polysaccharide Vaccine - PPV				
Inactivated Poliovirus - IPV / OPV				
Hepatitis A - HepA				
Hepatitis B - HepB				
Haemophilus influenza, type B - Hib				
Varicella - VZ				

PARENT/GUARDIAN AUTHORIZATION

This health form is correct as far as I know, and the person herein described has permission to engage in all camp activities, except as noted by me.

I hereby give permission to the medical personnel selected by White River Youth Camp to provide routine health care; to administer prescription and over-the-counter medications; to order X-rays, routine tests, treatment, sutures; to release any records necessary for insurance purposes; and to arrange necessary transportation for my child. In the event that I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by White River Youth Camp to hospitalize, secure proper treatment for, and to order injection anesthesia, or surgery for my child as named above. This form may be photocopied for trips out of camp.

Parent/Guardian Signature: ____________________________________ **Date:** ________________

Relationship to Camper: ____