Camper Medical Form

Camper's Name ____ ☐ Male ☐ Female
First Middle Last

Birthdate ______________ Age on arrival at camp ________
Month/Day/Year

Home Address ____

____
City State Zip Code

Parent /Guardian: ____

Phone: Primary (______) _______-________ Secondary (______) _______-________

Email: ______________________________

If not available in an emergency, notify: ______________________________

Phone: Primary (______) _______-________ Secondary (______) _______-________

Email: ______________________________ Relationship: ______________________

Name of Physician: ____

Phone: (______) _______-________ Fax: (______) _______-________

I ________ give permission for Camp Daybreak to contact the child's physician.
Initial

Insurance Information: Is the child covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, please indicate carrier or plan name :______________________ Group # __________

Allergies:

- ☐ **No known allergies**
- ☐ To Foods **(List)** ______________________________
- ☐ To Medications **(List)** ______________________________
- ☐ To the environment (insect stings, hay fever, etc) ________
  ____
- ☐ Other allergies **(List)** ______________________________

Has the child ever had?	**When?**
☐ Measles	________
☐ Chicken pox	________
☐ German measles	________
☐ Mumps	________
☐ Hepatitis A	________
☐ Hepatitis B	________
☐ Hepatitis C	________
☐ Whooping cough	________
☐ Lice	________

Describe previous reactions:

Have the child ever been prescribed an epi pen or inhaler?

- ☐ Yes, an epi -pen
  - Date __________
- ☐ Yes, an inhaler
  - Date __________
- ☐ No

*** If you answered "yes" to either of the above, one MUST be brought to camp with you.**

(For camp use only)

Name ________ First ________ Middle ________ Last ________

Family:________ Cabin ________

Camper Medical Form

Has the child/Does the child?

		Yes	No
1.	Had any recent injuries, illness, or infectious disease?..........	☐	☐
2.	Have a chronic or recurring illness/condition?	☐	☐
3.	Ever been hospitalized?..........	☐	☐
4.	Ever had surgery?..........	☐	☐
5.	Have frequent headaches?..........	☐	☐
6.	Ever had a head injury?..........	☐	☐
7.	Ever been knocked unconscious?..........	☐	☐
8.	Ever had frequent ear infections?..........	☐	☐
9.	Ever passed out?..........	☐	☐
10.	Ever had seizures?..........	☐	☐
11.	Had problems with diarrhea/constipation?...	☐	☐
12.	Have problems sleepwalking?..........	☐	☐
13.	Has a history of bedwetting?..........	☐	☐
14.	Ever had chest pains?..........	☐	☐
15.	Ever had high blood pressure?..........	☐	☐
16.	Ever been diagnosed with a heart murmur?	☐	☐
17.	Have any skin problems (e.g., itching, rash)?	☐	☐
18.	Have diabetes?..........	☐	☐
19.	Have asthma?..........	☐	☐
20.	Had mononucleosis in the last year?..........	☐	☐
21.	If female, has the child started menstruating?..........	☐	☐
22.	Ever had emotional difficulties for which professional help was sought?..........	☐	☐
23.	Have anxiety induced behavior when not at home (e.g., vomiting, headaches, passing out)?	☐	☐
24.	Ever had problems with joints (e.g., knees, ankles)?..........	☐	☐

Please explain any "yes" answers, noting the number of the questions.

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____

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____

Medication:

☐ No daily medications ☐ Will take the following prescribed medication(s) while at camp **(please be sure to ALSO complete the enclosed form with name, dose, and frequency)**

Do you feel like the child will require limitations or restrictions to activities while at camp? ☐ Yes ☐ No

*If you answered "yes" to the question above, please explain.

Important – These boxes must be complete for attendance

This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.

It is my intention that Camp Daybreak be treated as acting in *loco parentis* if the person herein named is a minor.

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including but not limited to x-rays, routine tests and treatment , and or hospitalization. I also give permission for the camp to arrange any related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

In the event that I cannot be reached in an emergency, I hereby give permission to the medical professional selected by Camp Daybreak to secure and administer treatment, including hospitalization.

Signature of parent or guardian ______________________________

Printed Name ______________________________ Date ______________________