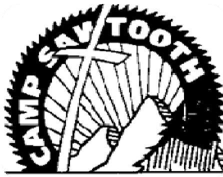

Camp Sawtooth

Camper Medical History Form - 2010

(Please Print)
Camper Name ______________________________ Camp Attending ______________

Camper Home Address ____

City ____________________________________ State __________ Zip ________

Birth Date _________ Age _____ Weight ______ Gender: Male / Female (Please circle)

Parent/Guardian to be contacted in case of emergency: ____________________

Home Address ____
(if different than above)
Home Phone: _______________ Cell #: ____________________ Cell #: ______________

Email: ____________________________________ Work Phone ______________

EMERGENCY CONTACT: In case you cannot be reached, please notify:

Name ____________________________________ Relationship: ______________

Home Phone _______________ Cell #: _______________

HEALTH HISTORY: Camper health and medical information needs to be made known to the camp. Camp personnel will hold this information in confidence. If insufficient space is provided, please attach additional paperwork.

ALLERGIES: List all known allergies and describe reaction and management of the reaction. ______________

____

Medication Allergies: ____

Food Allergies or Special Diet Needs: ____

____

Other Allergies: (include insect stings, hay fever, asthma, animal dander, etc.) ______________

____

Has your child experienced any of the following? Please circle number and explain all that apply.

1. Recent injury, illness or infectious disease?
2. Chronic or recurring illness?
3. Ever had measles?
4. Ever had chicken pox?
5. Ever been hospitalized?
6. Ever had surgery?
7. Frequent headaches?
8. Head injury?
9. Frequent ear infections?
10. Ever passed out during or after exercise?
11. Diabetes?
12. ADHD / ADD?
13. Heart disease?
14. If female, abnormal menstrual history?
15. Eating disorder?
16. Depression?
17. Sleep problems?
18. Psychiatric treatment?
19. Bed wetting (recently)?

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

Are there any other medical conditions or restrictions we should be aware of?

Explanation: (Attach additional sheet if needed) ______________________________

____

____

HEALTH INSURANCE:

Is this camper covered by family health insurance? _____ Insurance Company ______________________________

Subscriber's Name______________________________Group ID# ______________________________

IMMUNIZATIONS: (Dates are required)

Immunization	Dosage #1 month/year	Dosage #2 month/year	Dosage #3 month/year	Dosage #4 month/year	Dosage #5 month/year	Month/Year
DPT						xxxxxxxxxx
Tetanus booster	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	
MMR			xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx
Polio OPV/IPV						xxxxxxxxxx
TB Test	Positive?	Negative?				
Hepatitis B				xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx
Hepatitis A			xxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx
Menactra		xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx

If you child has not been immunized, please sign below indicating you are aware of the risks involved.

Signature of Parent or Guardian:______________________________ Relationship to camper:____________________Date:________

NON-PRESCRIPTION MEDICATIONS: Camp Sawtooth keeps over-the-counter medications stocked for campers who may need them. Please check those medications that your child may take/use if needed. These will be administered by the Health Care Volunteer.

____Acetaminophen (Tylenol)
____Ibuprofen (Advil, Motrin)
____Sudafed
____Benadryl
____Cough drops
____Sore throat spray
____Calamine lotion
____Pepto Bismol
____Kaopectate (for mild diarrhea)
____Hydrocortisone cream
____Antibiotic cream (Neosporin)
____Aloe (sunburn cream)

MEDICATIONS: List ALL medications including over-the-counter or non-prescription drugs taken routinely. Bring sufficient medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage and the frequency of administration. The camper's name must be written on all containers. Please do not take your child off regular medicines while at camp. Attach additional paperwork if needed. Identify any medications taken during the school year that participant does/may not take during the summer.

Medication #1 ______________________________Dosage____________________

Specific times to be taken each day ______________________________Reason for taking__________________

Medication #2 ______________________________Dosage____________________

Specific times to be taken each day ______________________________Reason for taking__________________

Medication #3 ______________________________Dosage____________________

Specific times to be taken each day ______________________________Reason for taking__________________

EPI PENS or INHALERS (Parent or Guardian please initial)

I give my child permission to carry an Inhaler and to self-administer. _____

I give my child permission to carry an Epi pen and to self-administer. _____

Health Care Volunteers should keep my child's Inhaler or Epi pin to help determine when needed. _____

TRANSPORTATION: My child will return home from camp with (name of person or church):

Name:____Relationship: ____________

Name:____Relationship: ____________

If above information changes, please contact Camp Sawtooth as soon as possible.

EMERGENCY AUTHORIZATION AND LIABILITY RELEASE:

This health history is correct so far as I know, and the camper described above has permission to engage in all camp activities except as noted. I have familiarized myself with the camp program and events and understand that all activities are completely voluntary. I recognize the inherent risk of injury in camp activities.

I understand that Camp Sawtooth has taken extensive safety measures, including the certification of its staff in first aid and CPR, as well as making every effort to aid the safety of all camp participants. However, I also recognize that Camp Sawtooth cannot insure or guarantee that the participants, equipment, grounds and/or activities will be free of accidents or injuries.

I am aware and have instructed my child in the importance of knowing and abiding by the camp's rules and regulations and do release Camp Sawtooth from all liability for any injury to the camper. I understand that transportation to and from camp (and any liability thereof) is the responsibility of the camper, and not that of Camp Sawtooth.

I give permission to the Camp Health Care volunteer to (1) administer the camper's routine medications, as needed' medications, and over-the-counter medications for minor illnesses or discomfort; (2) provide appropriate first aid for minor injuries; and (3) seek further treatment from local physician or hospital if condition warrants.

In the event I cannot be reached in an emergency, I give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for the camper named above. This completed form may be photocopied by the camp to have a second set available for Camp Sawtooth

I give permission for Camp Sawtooth to use any photo, video, or interview taken at camp to be used to illustrate report, promote and advertise Camp Sawtooth.

____

Signature of Parent/Guardian **Date**

MEDICAL FORM MUST BE COMPLETED AND RETURNED AT LEAST TWO WEEKS BEFORE CAMP

BEFORE MAY 15TH

Camp Sawtooth
PO Box 445
Homedale, ID 83628

(208) 337-3364

AFTER MAY 15TH

Camp Sawtooth
HC 64, Box 8290
Ketchum, ID 83340

(208) 726-1155

directorscampsawtooth@yahoo.com www.campsawtooth.org