

**CAMP HEALTH FORM - 2020**

Please attach a copy of the camper's immunization records to this form

LAST NAME	FIRST NAME	M.I.	D.O.B	GENDER	AGE
PARENT OR GUARDIAN			PHONE		
HOME ADDRESS					
CITY			STATE	ZIP	

**If you are NOT available, in an emergency, notify(must be different than above):**

EMERGENCY CONTACT NAME					
PHONE #'S (H)		(W)	(C)		
ADDRESS			CITY	STATE	ZIP

**PART 1: HEALTH CONCERNS (completed by parent/guardian):**

*\*For emergency/life-threatening conditions, please also attach action plan from clinic and include emergency medication for nurse*

- Food sensitivities (list food & reaction): \_\_\_\_\_

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- \*Allergies (allergen, reaction, & manner - ie: if touched, ingested, or airborne): \_\_\_\_\_

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- \*Asthma (list triggers): \_\_\_\_\_
- \*Diabetes (how it's managed - ie: oral meds, pump, injections): \_\_\_\_\_

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- \*Seizures (list triggers, description, and auras): \_\_\_\_\_

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- Heart Condition: \_\_\_\_\_
- Recent injuries, surgeries, or hospitalizations: \_\_\_\_\_
- Activity restrictions: \_\_\_\_\_
- Implanted devices: \_\_\_\_\_
- Bowel/Bladder concerns: \_\_\_\_\_
- Emotional/Social/Behavioral concerns: \_\_\_\_\_

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- Has the female camper menstruated yet? (list special instructions): \_\_\_\_\_
- Other concern: \_\_\_\_\_

**PART 2: MEDICATIONS** (ALL medications must arrive at camp pre-packaged/labeled BY PHARMACY) OR if an exception is allowed by camp leadership, in original bottles with correct pharmacy label:

Circle “yes” or “no” to give permission for the following medications provided by the camp (to be given only “as needed”):

Acetaminophen (Tylenol) for pain/fever	yes	no	Loperamide (Imodium) for diarrhea (*not given if fever)	yes	no
Ibuprofen (Motrin, Advil) for pain/fever	yes	no	Magnesium Hydroxide for constipation	yes	no
Diphenhydramine (Benadryl) for allergy	yes	no	Hydrocortisone cream 1% for skin irritation	yes	no
Cetirizine (Zyrtec) for seasonal allergy	yes	no	Triple Antibiotic cream for first aid	yes	no
Calcium Carbonate (Tums) for acid reflux	yes	no	Aloe, Calamine, Sunscreen, Bugspray, Cough Drops	yes	no

Special instructions for medications (ie: mix with applesauce): \_\_\_\_\_

List all prescription and (additional) non-prescription medication you request the camp nurse to administer. Please note- scheduled medication is preferred to be given during meal-times at camp, however, if an alternate time is requested, please be specific. Mealtimes are generally scheduled for- breakfast (8-9am), lunch (12-1pm), dinner (5-6pm), bedtime snack (8-9pm).

*\*Camp Wahode participants only receive prescription medication at lunch or as needed. Morning and evening medication should be administered outside of camp hours\**

Medication name	Dose	Route	Meal to be given (or other time)	Reason / Indication for PRN

Name of Prescriber (MD/DO/PA-C/NP): \_\_\_\_\_

Phone number: \_\_\_\_\_ Signature: \_\_\_\_\_

I attest to the information provided and I acknowledge it is my responsibility to inform the camp of any changes. I give permission for the camp nurse to confidentially exchange health information for use in meeting the camper’s health needs. I understand the camp nurse and designated staff will provide the camper with basic first aid treatment. In the event of an emergency, I hereby give permission to provide this camper with any further medical care deemed necessary by medical professionals selected by the camp. I furthermore, authorize the camp nurse and delegated staff to administer medication as indicated above.

Parent/Guardian Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PART 3: PHYSICAL EXAMINATION** (completed by licensed provider within 12 months of arrival at camp):

- Physicals are only required for Camp Hand in Hand and Camp Discovery. We do NOT require a physical for Wahode Day Campers.
- Per ACA regulations, physical examination forms for Hand in Hand and Discovery are required for submission every year; i.e. signed and dated within one year of camper participation.

**Has your camper submitted a doctor-signed AuSM physical examination form within 12 months of their expected camp participation date?**

**Yes-** However, I would like to submit an updated physical examination form for the 2020 camp season, to communicate changes to my campers' health. (Please fill out the form below, complete with doctor signature.)

**No-** (Please fill out the form below, complete with doctor signature.)

Date of last physical exam: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Indicate Normal (N) or Abnormal (AB) -include comments below if AB

	N	AB		N	AB		N	AB		N	AB
Eyes			Genitourinary			Extremities			Neurological		
Ears			Gastrointestinal			Abdomen			Heart		
Nose			Feet			Skin			Lungs		
Throat			Spine			Endocrine			Lymph		

Comments:

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Name of Provider (MD/DO/PA-C/NP):

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Phone number: \_\_\_\_\_

Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_