

# 2012 Boulder Ridge Day Camp Medical Form for Campers

Sessions Attending:  1  2  3  4

The information on this form is not part of the camper acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival to camp. Provide complete information so that we can be aware of your child's needs.

## Section 1: Parent Portion

To be completed and signed by the parent every year.

### CAMPER INFORMATION:

Name: First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age while at camp: \_\_\_\_ Sex:  Male  Female

Home Address: \_\_\_\_\_

Parent 1's Name: \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

Parent 2's Name: \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

If parents are not available, contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

### DIETARY AND EXERCISE RESTRICTIONS: (The following restrictions apply to this camper.)

Does not eat:  Red Meat  Pork  Dairy Products  Poultry  Seafood  Eggs  Other: \_\_\_\_\_

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary): \_\_\_\_\_

### ALLERGIES: (Please list all known.)

Describe reaction and management of reaction:

Food Allergies: \_\_\_\_\_

Medication Allergies: \_\_\_\_\_

Other Allergies: \_\_\_\_\_

### HEALTH HISTORY: (Please explain questions you answered YES to below.)

Has, or does the camper:

- |   | Yes                      | No                       |   | Yes                      | No                       |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Had any recent injury, illness, or infectious disease? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Have any skin problems (itching, rash, acne)?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have a chronic or recurring illness/condition ?        | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have an orthodontic appliance coming to camp?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ever been hospitalized?                                | <input type="checkbox"/> | <input type="checkbox"/> | 12. Had mononucleosis in the past 12 months?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Ever had surgery?                                      | <input type="checkbox"/> | <input type="checkbox"/> | 13. If female, have abnormal menstrual history?                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Wear glasses, contacts, or protective eyewear?         | <input type="checkbox"/> | <input type="checkbox"/> | 14. Ever had an eating disorder?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Ever had frequent ear infections?                      | <input type="checkbox"/> | <input type="checkbox"/> | 15. Ever had emotional difficulties for which professional help was sought? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ever had seizures?                                     | <input type="checkbox"/> | <input type="checkbox"/> | 16. Any recent exposure to contagious diseases?                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have diabetes?   | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 9. Have asthma?   | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |

If yes, please explain: \_\_\_\_\_

### USE OF BUG REPELLANT:

- My child may use the bug repellent containing DEET that is provided by Ebner Camps, Inc. in accordance with the instructions of the attending physician and manufacturers recommendations to prevent against bites from mosquitoes and ticks.
- My child may only use the bug repellent that I provide.

### USE OF SUNSCREEN:

- My child may use the sunscreen that is provided by Ebner Camps, Inc. in accordance with the instructions of the attending physician and manufacturers recommendations to prevent sunburn.
- My child may only use the sunscreen that I provide.

### EMPLOYEE ASSISTANCE WITH BUG REPELLANT AND/OR SUNSCREEN:

- My child may receive assistance with the application of bug repellent and/or sunscreen by an employee of Ebner Camps, Inc., when needed.
- My child may not receive assistance with the application of bug repellent and/or sunscreen by an employee of Ebner Camps, Inc.

- CONTINUED ON REVERSE -

Name: (Last, First)

# Section 1: Parent Portion

Camper's Name: \_\_\_\_\_

## PRESCRIPTION AND DAILY NON-PRESCRIPTION MEDICATIONS:

- This camper does not take any medications routinely.
- This camper does take medications routinely. List Medications: \_\_\_\_\_

In accordance with state law, each medication, either prescription or over the counter, that is taken routinely at camp, must have a completed medication administration form signed by the physician.

## NON-PRESCRIPTION MEDICATIONS:

The following medications are stocked in our infirmary and are available to be administered to your child in accordance with the standing orders of the camp physician and the dosage instructions provided on the medication packaging. Generic medications may be substituted for any of the medications listed below.

Please indicate whether or not the camp health personnel may administer these medications to your child if necessary:

	Yes	No		Yes	No
Robitussin (Guaifenesin Syrup)	<input type="checkbox"/>	<input type="checkbox"/>	Advil/Motrin (Ibuprofen)	<input type="checkbox"/>	<input type="checkbox"/>
Benadryl (Diphenhydramine)	<input type="checkbox"/>	<input type="checkbox"/>	Tylenol (Acetaminophen)	<input type="checkbox"/>	<input type="checkbox"/>
Cepacol (Benzocaine/Methol) Lozenges	<input type="checkbox"/>	<input type="checkbox"/>	Immodium (Loperamide)	<input type="checkbox"/>	<input type="checkbox"/>
Chloraseptic Spray (Phenol Spray)	<input type="checkbox"/>	<input type="checkbox"/>	Hydrocortisone cream	<input type="checkbox"/>	<input type="checkbox"/>
PeptoBismol (Bismuth Subsalicylate)	<input type="checkbox"/>	<input type="checkbox"/>	Betadine/Povidine	<input type="checkbox"/>	<input type="checkbox"/>
Roloids/Tums (Calcium Carbonate)	<input type="checkbox"/>	<input type="checkbox"/>	Bactine antiseptic spray	<input type="checkbox"/>	<input type="checkbox"/>
Midol (Acetaminophen/Pyrilamine maleate)	<input type="checkbox"/>	<input type="checkbox"/>	Visine (Tetrahydrozoline HCl)	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Rub (Camphor/Menthol cream)	<input type="checkbox"/>	<input type="checkbox"/>	Bacitracin (Triple antibiotic) ointment	<input type="checkbox"/>	<input type="checkbox"/>

### IMPORTANT—THIS BOX MUST BE COMPLETE FOR ATTENDANCE!

**Parent/Guardian Authorization:** This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I give permission for the above indicated medications to be dispensed in accordance with the camp doctor's standing orders and dosages provided on the medication packaging. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me. I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of Parent/Guardian: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

# Section 2: Physician Portion

All campers must have had a physical within 3 years preceding their first day of camp. The physician may complete and sign this section or attached a signed standard school or state form provided that it includes the same information. If you have a current (within three years) physical on file from summer 2011 at Boulder Ridge, you may skip this section.

Which of these has the camper had? Please give last booster date of the following immunizations:

Measles	<input type="checkbox"/>	DPT series: _____	TD (Tetanus/Diphtheria): _____	Polio OPV (Sabin): _____
Chicken Pox	<input type="checkbox"/>	MMR: _____	Mumps: _____	Measles: _____
German Measles	<input type="checkbox"/>	Influenza B: _____	Hepatitis B: _____	Varicella (chicken pox): _____
Mumps	<input type="checkbox"/>	TB Mantoux test: _____	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	
Hepatitis A	<input type="checkbox"/>	Height: _____	Weight: _____	BP: _____
Hepatitis B	<input type="checkbox"/>			Gross dental exam: _____
Hepatitis C	<input type="checkbox"/>			

Other: \_\_\_\_\_ Please use a separate sheet to provide any additional information about the camper's behavior and physical, emotional, or mental health that camp should be aware of.

Name of Camper's Physician: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Physician's Signature: _____	Physician's Printed Name: _____	Date Signed: _____	Date of last physical: _____
------------------------------	---------------------------------	--------------------	------------------------------