CAMPER HEALTH HISTORY FORM

PLEASE ATTACH A PHOTO OF CAMPER TO THIS FORM

STEP #1: CAMPER INFORMATION

ALL PARTICIPANTS MUST BE COVERED BY HEALTH INSURANCE

CAMPER'S NAME: | D.O.B: | GENDER:

HOME ADDRESS: | HOME PHONE #:

CITY, COUNTY, STATE, ZIP:

PHYSICIAN'S NAME: | PHYSICIAN'S PHONE #:

PREFERRED HEALTH CARE FACILITY:

HEALTH INSURANCE CARRIER:

POLICY #: | GROUP #:

A COPY OF THE FRONT AND BACK OF THE INSURANCE CARD MUST BE ATTACHED TO THIS FORM

SECTION #2: MEDICAL HISTORY INFORMATION

ATTACH A SEPARATE SHEET IF NECESSARY

DESCRIPTION OF ANY PAST MEDICAL TREATMENT (INCLUDE DATES OF TREATMENT)

PLEASE DESCRIBE ANY CURRENT PHYSICAL, MENTAL OR PSYCHOLOGICAL CONDITIONS REQUIRING MEDICATION, TREATMENT, OR SPECIAL RESTRICTIONS OR CONSIDERATIONS WHILE AT CAMP:

HAS YOUR CHILD EVER BEEN ON A MEDICATION FOR BEHAVIOR OR EMOTIONAL PROBLEMS? PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN HOSPITALIZED FOR A MENTAL OR EMOTIONAL PROBLEM? IF SO, PLEASE EXPLAIN WHEN, FOR HOW LONG, AND WHAT WAS THE DIAGNOSIS?

DESCRIPTION OF ANY CAMP ACTIVITIES FROM WHICH THE CAMPER SHOULD BE EXEMPTED FOR HEALTH REASONS:

ALLERGIES (INCLUDE FOOD, DRUGS, BEE STINGS, ETC):

DIETARY RESTRICTIONS (VEGETARIAN, RELIGIOUS, ETC):

MEDICATIONS: PLEASE LIST ALL CURRENT MEDICATIONS INCLUDING PRESCRIBED AND OVER-THE-COUNTER DRUGS TAKEN. ATTACH A SEPARATE SHEET IF NECESSARY.

MEDICINE #1: | DOSAGE: | TIME TAKEN EACH DAY:

REASON FOR TREATMENT:

MEDICINE #2: | DOSAGE: | TIME TAKEN EACH DAY:

REASON FOR TREATMENT:

MEDICINE #3: | DOSAGE: | TIME TAKEN EACH DAY:

REASON FOR TREATMENT:

MEDICINE #4: | DOSAGE: | TIME TAKEN EACH DAY:

REASON FOR TREATMENT:

WE DO NOT REQUIRE THAT YOU SUBMIT A COPY OF YOUR CHILD'S IMMUNIZATION RECORD, BUT DO REQUIRE THAT YOU ANSWER THE QUESTION BELOW:

DO YOU ATTEST THAT ALL IMMUNIZATIONS REQUIRED FOR SCHOOL ARE UP TO DATE FOR YOUR CHILD? YES ◯ NO ◯

WE DO REQUIRE THE LAST DATE (MONTH/YEAR) OF YOUR CHILD'S LAST TETANUS SHOT. DATE OF LAST SHOT:

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SECTION #3: PARENT/GUARDIAN PERMISSION TO TREAT AGREEMENT

This Medical Release states the risks of illness, injury, harm, and medical procedures at CCWA-PARADISE FARM CAMPS. It has important legal consequences. You should decide to send your child to camp only after you have read and understood the Medical Release Statement and decided that you wish you and your child to be bound by its terms. For your convenience, you (or each of you) is referred to in the Agreement as "I" and your child is referred to as "my camper" and the Children's Country Week Association and all of its officers, directors, employees and agents are referred to together as the "Association."

I am the parent or legal guardian of _____ (Camper's Name). I understand that camping has many risks. It involves such things as vigorous physical activity, the close gathering of large groups of people, communal living arrangements, and a rural outdoor setting. Participation in camp activities may entail exposure to serious risks posed by the natural and/or outdoor environment, such as tick borne diseases including Lyme Disease and Rocky Mountain Spotted Fever, Poison Ivy, etc.

If my camper becomes ill or is injured while at camp; I understand that my camper will first be evaluated by the Camp Health Service Provider or a Physician selected by the Association, and I authorize him or her to make all inquires, examinations and tests he or she deems necessary or appropriate. If he or she determines that it is appropriate to administer treatment at the Camp, I authorize that treatment. I release the Association from all liability which may result from the evaluation and treatment of my camper by the Camp Health Service Provider or that Physician.

If the Camp Health Service Provider or that Physician determines that other treatment is necessary or appropriate, I want the Association to try to reach me or those emergency contacts designated in the registration form in the order listed.

If reached, I will tell you whether and by whom I wish my camper to be treated. In an emergency, or if I cannot be reached in a timely fashion, I authorize the Association to deliver my camper to a Health Care Provider selected by the Association, for such treatment as that Provider considers appropriate. I agree that the Association shall not be responsible for what happens after my camper has been returned to me or delivered to a Health Care Provider so chosen by me or the Association, and I release it from all liability therefore. I agree that I am responsible for the cost of any outside health care provided and the cost of transporting my camper.

The undersigned agrees to be bound by and to have the undersigned's camper be bound by this agreement.

SIGNATURE	PRINT NAME:
	DATE:

SECTION #4: HEALTH EXAM

ATTACH ADDITIONAL INFORMATION IF NEEDED

THIS SECTION IS ONLY REQUIRED FOR CHILDREN ATTENDING ANY OVERNIGHT SESSION, AND MUST BE SIGNED BY A LICENSED PHYSICIAN

ACA ACCREDITATION STANDARDS SPECIFY PHYSICAL EXAM WITHIN THE LAST 12 MONTHS.

MEDICAL PERSONNEL: PLEASE REVIEW THE FRONT OF THE CAMPER HEALTH HISTORY FORM AND COMPLETE THE REMAINING SECTIONS OF THIS FORM.

PHYSICIAN'S NAME:	DATE OF EXAMINATION:

HEIGHT:	WEIGHT:	BP:	BLOOD TYPE:

DO YOU FEEL THAT THE CAMPER WILL REQUIRE LIMITATIONS OR RESTRICTIONS TO ACTIVITY WHILE AT CAMP ☐ YES ☐ NO

IF YES, WHAT ARE YOUR RECOMMENDATIONS:

PAST OR CURRENT HISTORY: PLEASE CHECK ALL THAT APPLY

- ☐ ASTHMA
- ☐ DIABETES
- ☐ CHRONIC, RECENT OR RECURRING ILLNESS
- ☐ CARDIOVASCULAR DISORDERS
- ☐ NEUROLOGICAL DISORDERS
- ☐ BED WETTING
- ☐ SKIN PROBLEMS
- ☐ GASTROINTESTINAL PROBLEMS
- ☐ SEIZURES
- ☐ EMOTIONAL/BEHAVIORAL
- ☐ DEVELOPMENTAL PROBLEMS
- ☐ OTHER MEDICAL CONCERNS

OTHER CONCERNS:

- ☐ MEASLES
- ☐ CHICKEN POX
- ☐ GERMAN MEASLES
- ☐ MUMPS
- ☐ HEPATITIS A
- ☐ HEPATITIS B
- ☐ HEPATITIS C

I HAVE REVIEWED THE CAMPER HEALTH HISTORY FORM, AND HAVE DISCUSSED THE CAMP PROGRAM WITH THE CAMPER'S PARENT(S)/GUARDIAN(S). IT IS MY OPINION THAT THE CAMPER IS PHYSICALLY AND EMOTIONALLY FIT TO PARTICIPATE IN AN ACTIVE CAMP PROGRAM (EXCEPT AS NOTED ABOVE.)

SIGNATURE	OFFICE ADDRESS:
DATE:	PHONE #:

ALL CAMPERS MUST HAVE A CURRENT HEALTH HISTORY FORM RETURNED TO THE CAMP OFFICE WITHIN 60 DAYS OF REGISTRATION OR BY AUGUST 1ST, WHICHEVER COMES FIRST. ANY CAMPER WITHOUT A CURRENT HEALTH HISTORY FORM SUBMITTED BY THE DUE DATE MAY HAVE THEIR REGISTRATION REMOVED.

ANY QUESTIONS OR CONCERNS, PLEASE CONTACT LEAH AT 610.269.9111 x2013.