Camper Name:

CAMP GROW MEDICAL FORM

A separate form is required for each child at camp.

Camper Name:_____Birth Date:____/_____/_____

Home Phone:_____-_____-_____

Custodial Parents

	Mother	Father
Full Name		
Cell Phone		
Work Phone		
Other Phone		

Emergency Contact Information

In case of emergency, we will first attempt to contact parents and then contact names on Emergency Contact list.

Name	Relationship to Camper	Phone

Family Health Care Providers

	Name	Phone
Primary Physician		
Dentist		
Orthodontist (if applicable)		
Mental Health Provider		

Health Insurance

Insurance Carrier:_____

Carrier Address:_____ Carrier City, State, Zip:_____

Policy Number:_____ Group Number: _____

Name of Insured:_____ Relationship to Camper:_____

Insured's Insurance ID Number:_____

Prescription Plan Carrier:_____ Prescription Plan Number:_____

Please photocopy both sides of your family's insurance and prescription cards and attach to this form.
Make sure copies are legible.

NOTE: If you have more than one child at camp this season, this page need only be completed once.

Camper Name:

Camper Health History

Indicate the following by entering an approximate date of last occurrence. Leave blank if not applicable.

Disease	Date	Disease	Date
Chicken Pox	_____	Mumps	_____
Measles	_____	Asthma	_____
German Measles	_____	Hepatitis (A, B, or C)	_____

Please notify the camp if the camper is exposed to any communicable disease during the 3 weeks prior to camp attendance.

Allergies:
Check all that apply and include description of critical allergic reactions.

Non-Dietary:
- ☐ Hay Fever
- ☐ Poison Ivy, Oak, etc.
- ☐ Insect Stings
- ☐ Penicillin
- ☐ Latex
- ☐ Other (specify): _____

Dietary:
- ☐ Peanut
- ☐ Tree Nut
- ☐ Shellfish
- ☐ Flat fish
- ☐ Wheat
- ☐ Whey/Dairy
- ☐ Eggs
- ☐ Other (specify): _____

Description of Allergic Reactions:

Dietary Preferences
- ☐ Vegetarian
- ☐ No Dairy
- ☐ No Eggs
- ☐ No Pork
- ☐ No Red Meat
- ☐ No Seafood
- ☐ No Poultry
- ☐ No Gluten

Other Specific Dietary Considerations:

General Health Questions. Please check any that apply and explain in the space at the bottom of the page.
- ☐ Frequent headaches
- ☐ Frequent ear infections
- ☐ Back problems
- ☐ Diarrhea/Constipation
- ☐ Seizures/Convulsions
- ☐ Bleeding/Clotting
- ☐ Head injury
- ☐ Eating disorder
- ☐ Bed wetting
- ☐ Diabetes
- ☐ Heart murmur
- ☐ Concussion or knocked unconscious
- ☐ Skin problems (itching, rash, eczema, severe acne)
- ☐ Joint problems (ankles, knees, elbows, etc)
- ☐ Sleep walking
- ☐ High blood pressure
- ☐ Mononucleosis (past 12 months)
- ☐ Orthodontic appliance required at camp
- ☐ Glasses or contacts required at camp
- ☐ Emotional issues referred to treatment
- ☐ Chronic or recurring illness:_____
- ☐ Operations or serious injuries: _____
- ☐ Other:_____

Comments:

Camper Name:

Immunization

Please record the date (MM/YYYY) of basic immunizations and the most recent booster doses.
Alternatively, you may attach a copy of your child's immunization records.

DTP					
TD (Tetanus/Diptheria)					
Tetanus					
Polio					
Haemophilus, Influenza B					
Hepatitis B					
Varicella (Chicken Pox)					
MMR					
Other					

TB Test	Date:	□ Positive	□ Negative

Has your child ever tested positive for HIV? □ Yes □ No

Mental/Emotional Health

Please check any that apply and explain below:
□ Diagnosis of ADD, ADHD, or other attention-related disorder
□ Diagnosis of depression, OCE, panic/anxiety disorder
□ Significant learned or processing challenge (disability)
□ Currently seen by professional for mental/emotional health concerns
□ Treated with medications for mental/emotional issues
□ Other emotional health concerns

If any of the above are checked, please have the mental health professional send a written statement to the camp describing:
a) The condition and treatment plan, including any medications
b) Any behavior at camp that indicates to the staff that the camper needs a professional referral
c) A recommendation for participation in our camp program

If medication for any of the above has been prescribed, also provide:
d) Certification that the camper has been taking the same medication at the same dosage for 3 months prior to the start of camp
e) If (d) is not true, a detailed explanation for the change in medication and explanation of possible side effects

Comments:

Camper Name:

Medications

Send enough medications to last throughout your child's stay at camp. Keep all medications in the original packaging. Prescription labels must include camper name, drug name, dosage, time(s) of delivery, and physician's name.

Please list all medications that camper will be taking routinely while at camp, including over-the-counter or other non-prescription drugs.

Medication (or common name)	Dosage	Delivery	Physician
1.		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ As Needed ☐ Until ___/____	Name: Phone Number:
2.		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ As Needed ☐ Until ___/____	Name: Phone Number:
3.		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ As Needed ☐ Until ___/____	Name: Phone Number:
4.		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ As Needed ☐ Until ___/____	Name: Phone Number:
5.		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ As Needed ☐ Until ___/____	Name: Phone Number:
6.		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ As Needed ☐ Until ___/____	Name: Phone Number:
7.		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ As Needed ☐ Until ___/____	Name: Phone Number:

Special Medication Instructions:

Camper Name:

Custodial Parent's Authorization

THIS AUTHORIZATION MUST BE COMPLETED FOR ATTENDANCE

By my signature below, I certify the following:

The Health History is complete and correct to the best of my knowledge. The camper named has permission to engage in all camp activities except where noted.

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for 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 related transportation. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

It is my intention that the camp be treated as acting ***in loco parentis*** if the camper herein named, is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as 'personal representatives' for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510 (b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (1) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (2) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above.
I understand that part of the camp experience involves activities and group living arrangements and interactions that may be new to my child, and that they come with certain risks and uncertainties beyond what my child may be used to dealing with at home. I am aware of these risks, and I am assuming them on behalf of my child. I realize that no environment is risk-free, and so I have instructed my child on the importance of abiding by the camp's rules, and my child and I both agree that he is familiar with these rules and will obey them.

_____ _____

Signature Date

Camper Name:

CAMP GROW
GREEN RIVER OUTREACH FOR WILDERNESS

Physician's Examination

Please have your camper's physician fill out this form within 12 months of arrival at camp. A copy of a sports physical or school physical form within the last school year is an acceptable replacement. The purpose of the examination is to determine physical fitness to engage in strenuous activity at camp.

Patient: _____, _____
(Last) (First)

Address: _____City/State/Zip _____

Codes: V- Satisfactory X – Not Satisfactory O – Not examined

Height: _____ Weight: _____ Heart: _____ BP: _____

Hct/Hgb Test: _____ Urinalysis: _____

Eyes: _____ Ears: _____ Nose: _____ Throat: _____ Lungs: _____

Glasses: _____ Skin: _____ Posture: _____ Other:_____

Allergy (Please specify): _____

General Appraisal: _____

Is this person up to date on all routine childhood immunizations? _____ Yes _____ No

Date of Last Tetanus Shot: _____

RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP

Special Diet: _____

Current Medications: _____

Swimming/Diving: _____

Strenuous Activity: _____

Other: _____

I have examined the person herein described and have reviewed the health history. It is my opinion that this person is physically able to engage in camp activities, except as noted above.

_____ _____
(Examining Physician) (Telephone)

_____ _____
(Date) (Address)