CAMPER MEDICAL FORM

This form must be completed in full and include a copy of both sides of your family insurance card and a current immunization record for your camper. This form must be completed IN ADDITION TO THE CAMPER PHYSICAL FORM.
Please note: if you registered for camp online, you have already completed this form online.

Camper Name:___________________________________ Date of Birth:________________________ Grade:_____________

Camper Home Address: (street)__________________________________(City/ST)__________________(zip)_____________

Camp Session Date(s):_____________________________

Parent/Guardian with legal custody of camper to be contacted in case of illness/injury:

Name:___________________________Relation to Camper:__________________ Pref. Phone #1:_(____)_______________

Pref. Phone #2:_(____)___________________ Email:____

Home Address:____________________________________(City/ST)_______________________(zip)_________________
(if different from above)

Second Parent/Guardian and/or other emergency contacts:

Name:___________________________Relation to Camper:__________________ Pref. Phone #1:_(____)_______________

Pref. Phone #2:_(____)___________________ Email:____

Name:___________________________Relation to Camper:__________________ Pref. Phone #1:_(____)_______________

Pref. Phone #2:_(____)___________________ Email:____

Allergies: ___NO known allergies

__To Foods (LIST):
__To Medications (LIST):
__To the Environment (LIST):
__Other (LIST):
Describe previous reactions:

Diet/Nutrition: __ Eats regular diet

__Has medically prescribed meal plan or dietary restrictions (describe below):

Restrictions:

☐ I have reviewed the program and activities offered at Camp Hochelaga and feel that this camper can participate in all activities offered without restrictions.

☐ I have reviewed the program and activities offered at Camp Hochelaga and feel that this camper can participate with the following restrictions or adaptations (describe):

Medical Insurance Information:

This camper is covered by family/hospital insurance: ☐ YES **(ATTACH PHOTO COPY OF CARD TO THIS FORM)** ☐ NO

Policy Holder Name:____

Insurance Company:__________________________________ Policy Number:_____________________________________

Subscriber:____ Insurance Company Phone #:_(_____)___________________

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately represents the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian:____ Date:___________________

IMMUNIZATION HISTORY

ATTACH COPY OF CURRENT IMMUNIZATION RECORD TO THIS FORM

If your camper has not been fully immunized, please sign the following statement: I understand and accept, as the custodial parent/guardian of this camper, the risks to my child from not being fully immunized.

Signature of Custodial Parent/Guardian:____ Date:___________________

Medication:

☐ This camper will not take any daily medications while at camp

☐ This camper will take the following daily medications while at camp. I will provide all medications in their original prescription bottles and understand that Camp Hochelaga will administer my camper's medications per written prescription on each bottle.

"Medication" is any substance a person takes to maintain and/or improve health, including vitamins, OTCs, supplements.

Please list medications to be given at camp:

Name of medication	Date started	Reason for taking	Time(s) Given	Dose	Method

If deemed appropriate, Camp Hochelaga's Health Team may administer Over The Counter (OTC) medication to this camper:

☐ YES, except for the following OTC medications:____

☐ NO, Camp Hochelaga may not give this camper OTC medications.

GENERAL HEALTH HISTORY

Has/does this camper:

1. Ever been hospitalized? __YES __NO
2. Ever had surgery __YES __NO
3. Have a recurring/chronic illness? __YES __NO
4. Had a recent infectious disease? __YES __NO
5. Had a recent injury? __YES __NO
6. Had asthma/wheezing/short of breath? __YES __NO
7. Have diabetes? __YES __NO
8. Had seizures? __YES __NO
9. Had headaches? __YES __NO
10. Wear glasses or protective eyewear? __YES __NO
11. Had fainting or dizziness? __YES __NO
12. Passed out/had chest pain? __YES __NO
13. Had "mono" during past 12 months? __YES __NO
14. Had problems with periods? __YES __NO
15. Have problems falling/staying asleep? __YES __NO
16. Had back/joint problems? __YES __NO
17. Had history of bed wetting? __YES __NO
18. Have problems with diarrhea/constipation? __YES __NO
19. Have skin problems? __YES __NO
20. Travelled outside country in past 9 months? __YES __NO

Please explain any YES answers here:

Mental, Emotional, and Social Health:

Has this camper:

1. Ever been treated for attention deficit disorder or attention deficit/hyperactivity disorder? __YES __NO
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? __YES __NO
3. During the past 12 months seen a professional to address mental/emotional health concerns? __YES __NO
4. Had a significant life event that continue to affect the campers life? __YES __NO

Please explain any YES answers here:

Health Care Providers:

Name of Camper's Primary Care Doctor(s):________________________________ Phone:_(_____)___________________

Name of Dentist:____ Phone:_(_____)___________________

HAVE WE FORGOTTEN ANYTHING?

Please use the space below to note any additional information you think Camp Hochelaga should have to keep your camper safe and healthy at camp. Please attach any additional information to this form if needed.