

Camp Downer Health Statement and Parent/Guardian Approval Form

(To be completed by parent or guardian)

Do Not Mail This Form-Bring To Registration!

(For confidential use by camp staff and health care professionals as needed.)

Camper Name: _____ (Last Name, First Name, Middle Initial)

Street Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth (Month, Day, Year): _____ Age: _____

1. Check all medical conditions camper has:

- Asthma
- Frequent Earaches
- Heart Disease
- Rheumatic Fever
- Hearing
- Emotional/behavioral
- Epilepsy
- Diabetes
- Vision Problems
- Physical challenges, injuries, orthopedic
- Serious illness in past year
- Dietary Restrictions - If checked, please complete Dietary Restrictions Form (**Attachment A**).
- Pre-Existing Injury - If checked, Physician must complete Pre-Existing Injury Form (**Attachment B**).
- Allergies (List All): _____

Comments on medical conditions:

2. Has the camper:

- a. Had loss of eye, lung, kidney, ovary or testes? Yes No Specify: _____
- b. Had loss of vision or hearing? Yes No Specify: _____
- c. Had loss of consciousness with head injury? Yes No Specify: _____
- d. Any serious illness in the last year? Yes No Specify: _____
- e. Started menstruating? Yes No

3. Will the camper:

- a. Wear glasses at camp? Yes No
- b. Wear contact lenses at camp? Yes No
- c. Wear a hearing aid at camp? Yes No

4. Does the camper:

- a. Take prescribed medication of any kind? Yes No
- b. If yes, will camper have to take it during camp? Yes No

If YES, you must attach the enclosed Camper Medication Dispensing Form (Attachment C) completed and signed by the camper physician.

5. Does the camper have a known sensitivity to any medication such as penicillin, aspirin, etc?

Yes No If yes, what medications? _____

6. Has camper been exposed to any contagious disease within the last three weeks such as strep throat, measles, mumps, lice, etc?

Yes No If yes, which contagious diseases? _____

Continued...

7. Please indicate last medical exam information:

Name of examining physician/clinic, health center or school: _____

Date of Exam: Month: _____ Year _____

EVERY CAMPER MUST SHOW PROOF OF HAVING HAD A PHYSICAL EXAMINATION WITHIN THE TWO YEARS PRIOR TO ATTENDING CAMP. Please attach a copy of a physical examination form to this form. If this camper has not had a physical examination within the last two years, the attached Comprehensive Physical Form (Attachment D) (or a signed statement by the examining family physician, clinic, health center, or school that it is safe for the camper to participate in camp) must be completed and must accompany this statement.

8. Immunizations:

Include the attached Immunization Form (Attachment E) with this health form. The Vermont Department of Health recommends that prior to arrival at camp, each camper must provide a record showing that immunization requirements have been met.

9. Please list any activities in which you do not want your camper to participate:

10. Camper's Physician Information

Name: _____ (Last Name, First Name, Middle Initial)

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

11. Health Insurance Information (To cover emergency treatment):

Camper Social Security Number: _____ - _____ - _____ (Requested by emergency providers.)

Insurance Company Name: _____

Insurance Policy Number: _____

Insurance Coverage via Parent/Guardian Policy? Yes No

Name of Employer for the Insured Policy Holder: _____

Name of Policy Holder: _____

12. Signature Acknowledgement:

To the best of my knowledge, my son/daughter/camper is in good health and can participate in this activity. I have indicated above any reasonable accommodations needed to meet my son/daughter's mobility, vision, hearing or other needs, as well as any health problems or medical conditions that may interfere with his/her participation.

By signing below, I hereby give permission for the listed camper to participate in Camp Downer's camping program and I also give permission to the group leader(s) to obtain necessary medical treatment for my son/daughter/camper in the event I cannot be reached in an emergency. I understand that the camp shall not be liable for expenses associated with any medical treatment for injuries my son/daughter/camper may sustain by virtue of his/her participation in the program.

Parent/Guardian Signature: _____ Date: _____

Printed Name of Parent/Guardian: _____

Parent/Guardian Home Phone(s): _____

Parent/Guardian Work Phone(s): _____

Parent/Guardian Cell Phone(s): _____

Parent/Guardian Home Address: _____

If you can not be reached, please give (in order) the name and phone number of parent/guardian(s) we should contact:

Name: _____ Relationship: _____ Phone _____

Name: _____ Relationship: _____ Phone _____

ATTACHMENT B
Camper Pre-Existing Injury Form

(To be completed by the camper's physician as needed.)

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Camper Name: _____ (Last Name, First Name, Middle Initial)

Street Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth (Month, Day, Year): _____ Age: _____

Nature of injury:

Date of injury: _____

Any disability? None _____ Yes _____

If yes, what? _____

Any limitation of physical activities? None _____ Yes _____

If yes, what? _____

Comment or recommendation: None _____ Yes _____

If yes, what? _____

Date of examination : _____

Signature of Physician: _____ Date: _____

ATTACHMENT C
Camper Medication Dispensing Form

(Must be completed by the parent/guardian and as need by camper's physician)

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(For confidential use by camp staff and health care professionals as needed.)

Camper Name: _____ *(Last Name, First Name, Middle Initial)*
Street Address: _____
City: _____ State: _____ Zip Code: _____
Date of Birth *(Month, Day, Year)*: _____ Age: _____

Prescription medication must be brought in a container appropriately labeled by pharmacy or Physician. All medication must be labeled and prescribed for this camper only. An original prescription labeled bottle must be in our possession before dispensing medications at camp. No medication will be given without this information:

Medication #1: _____
Dosage: _____
Directions: _____
Reason for prescription: _____

Medication #2: _____
Dosage: _____
Directions: _____
Reason for prescription: _____

Medication #3: _____
Dosage: _____
Directions: _____
Reason for prescription: _____

Signature of Physician: _____ Date: _____

Parent/Guardian Signatures Required:
I hereby give permission for Camp Downer health care providers to dispense medicine to my child:
Prescriptions listed above: YES OR NO (Circle One)
Non-Prescription medication: YES OR NO (Circle One)

Please note any exceptions for Non-Prescription medications:

Parent/Guardian Signature: _____ Date: _____

ATTACHMENT D
Camper Comprehensive Physical Form

(To be completed by the camper's physician as needed, see below)

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(For confidential use by camp staff and health care professionals as needed.)

EVERY CAMPER MUST SHOW PROOF OF HAVING HAD A PHYSICAL EXAMINATION WITHIN THE TWO YEARS PRIOR TO ATTENDING CAMP

Please attach a copy of a physical examination form to the Health Statement and Parent/Guardian Approval Form. If this camper has not had a physical within the last two years, this Comprehensive Physical Form -or- a signed statement by a physician, clinic or health center, must be completed.

Camper Name: _____ *(Last Name, First Name, Middle Initial)*
Street Address: _____
City: _____ State: _____ Zip Code: _____
Date of Birth *(Month, Day, Year)*: _____ Age: _____

Camper's Physician Information:
Name: _____ *(Last Name, First Name, Middle Initial)*
Street Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____

Medical History (Check any that apply):
 Loss of eye, lung, kidney or other organ
 Loss of vision or hearing
 Loss of consciousness with head injury
 Serious illness in the past year
 Serious accident in the past year
 Exposed to contagious disease in the past month
 Physical/mental/emotional problem we should be aware of
 Takes prescribed medication (Physician must fill out Attachment C Camper Medication Dispensing Form)
 Known sensitivity to any medications
 Medical problems/Diagnosis

Comments on Medical History:

General condition summary:

Check the diseases or vaccinations the individual has had:
 Measles
 Mumps
 German Measles
 Chicken Pox
 Whooping Cough

Signature of Physician: _____ Date: _____

ATTACHMENT E Camper Immunization History Form

(To be completed by the camper's physician as needed, see below)

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(For confidential use by camp staff and health care professionals as needed.)

The State of Vermont recommends that each camper provide a record showing that immunization requirements have been met. Provide information below from your records or consult your physician.

Camper Name: _____ (Last Name, First Name, Middle Initial)

Street Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth (Month, Day, Year): _____ Age: _____

DTP, DT or Td or Tdap

Number Of Vaccine	1	2	3	4	5	Ten Year Booster
Date (Month, Day, Year)						
Circle Type Of Vaccine	DTP - DT - Td	DTP - DT - Td	DTP - DT - Td	DTP - DT - Td	DTP - DT - Td	Tdap

POLIO

Number Of Vaccine	1	2	3	4
Date (Month, Day, Year)				
Circle Oral or Injection	ORAL INJECTION	ORAL INJECTION	ORAL INJECTION	ORAL INJECTION

HEPATITIS B

Number Of Vaccine	1	2	3
Date (Month, Day, Year)			

MEASLES

(1st dose must have been received on or after the first birthday. (Measles, Mumps and Rubella) is preferred vaccine.)

MMR

Number Of Vaccine	1	2
Date (Month, Day, Year)		

If camper had measles disease diagnosed by physician list date: _____ (month, day, year)

RUBELLA

Date of one required dose: _____ (month, day, year)

Rubella immunity confirmed by blood test: Titer result: _____ Date of test _____ (month, day, year)

If there is a Medical, Religious, or Personal reason why immunization is incomplete, please circle reason and explain:

Parent/Guardian Signature: _____ Date: _____