ADMIN ONLY: Week_____ Cabin_____ Clan_____

Camp Downer Health Statement and Parent/Guardian Approval Form

To be completed by parent or guardian. Please PRINT and Please use blue or black ink only.
DO NOT MAIL THIS FORM...BRING TO REGISTRATION PLEASE!
(For confidential use by camp staff and health care professionals as needed.)

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

1. Check all medical conditions camper has:

___ Asthma

___Allergies (List All): _____
_____
_____
_____
_____

___Chronic Diseases: _____
_____

___Diabetes

___Dietary Restrictions
(If checked, please complete Dietary Restrictions Form **(Attachment A)**).

___Emotional/Behavioral

___Epilepsy

___Frequent Earaches

___Hearing Problems

Will the camper wear a hearing aid at Camp? ___Yes ___No

___Heart Disease

___Physical challenges, injuries, orthopedic

___Pre-Existing Injury
(If checked, Physician must complete Pre-Existing Injury Form **(Attachment B)**).

___Rheumatic Fever

___Vision Problems
Will the camper wear glasses in Camp?
___Yes ___No

Will the camper wear contacts in Camp?
___Yes ___No

___Other (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:_____
Date:_____ Activity Restrictions: _____
d. Any serious illness in the last year? ___Yes ___No Specify:_____
e. Started menstruating? ___Yes ___No

3. Does the camper...

a. Take prescribed medication of any kind? ___Yes ___No
b. Take any over the counter medication? ___Yes ___No
c. If a. or b. is 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's physician.

4. Does the camper have a known sensitivity to any medication such as penicillin, aspirin, etc?
___Yes ___No If yes, what medications? _____

5. 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...

6. 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.

7. Immunizations:
All campers must either:
A) attach a printed report of immunizations from their health care provider, or
B) complete the attached Immunization Form (Attachment E) or
C) complete and attach a Vermont Department Of Health Medical or Religious Exemption Form.

Camp Downer does not accept Philosophical Exemptions.

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

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

10. 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:_____

11. 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.

Sign Here Parent/Guardian Signature: _____ Date: _____
Printed Name of Parent/Guardian: _____
Relationship to Camper:_____
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 A
Dietary Restrictions Form

To be completed by parent or guardian. Please PRINT and Please use blue or black ink only.

Camper Last Name:_____ Camper First Name:_____

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

The dates that your child will be attending camp:_____

Dietary Restrictions: (Please check one.)

___My child has NO dietary restrictions
(If your child has no dietary restrictions do NOT make a photocopy of this form and do NOT mail it to camp.)

OR

___My child HAS dietary restrictions
Please complete this form and make a photocopy. Please bring original to registration. Please mail the photocopy prior to June 1st to: Camp Downer, 70 S. Winooksi Ave. #196 , Burlington, VT 05401. After June 14th mail to: Camp Downer, 1535 Downer Rd., Sharon, VT 05065. The advance copy will allow our kitchen to be able to provide more balanced alternatives as needed.
(For confidential use by camp staff and health care professionals as needed.)

Check any that apply to this camper:
___Does not eat red meat
___Does not eat poultry
___Does not eat pork
___Does not eat seafood
___Does not eat eggs
___Does not eat dairy products
___Does not eat gluten
___Does not eat nuts. Camp Downer is NOT a nut free camp. This includes both peanuts and tree nuts.
___Is camper's diet vegan? ___Yes ___No
___Other-Please describe:

_____

_____

_____

_____

_____

_____

_____

_____

Sign Here Parent/Guardian Signature: _____ Date: _____

ATTACHMENT B

Camper Pre-Existing Injury Form

To be completed by parent or guardian. Please PRINT and Please use blue or black ink only.

Do Not Mail This Form-Bring To Registration!

To be completed by parent or guardian. Please PRINT and Please use blue or black ink only.

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

Camper Last Name:_____ Camper First Name:_____

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

___My camper DOESN'T have a preexisting injury.

OR

___My camper HAS a preexisting injury.

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 :_____

Sign Here Signature of Physician: _____ Date: _____

Sign Here Parent/Guardian Signature: _____ Date: _____

ATTACHMENT C

Camper Medication Dispensing Form

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

Do Not Mail This Form - Please Bring To Registration!

To be completed by parent or guardian. Please PRINT and Please use blue or black ink only.

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

Camper Last Name:_____ Camper First Name:_____

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

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:

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

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

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

Prescription Medication #4: _____
Dosage: _____
Directions: _____
Reason for prescription: _____

Prescription Medication #5: _____
Dosage: _____
Directions: _____
Reason for prescription: _____

Prescription Medication #6: _____
Dosage: _____
Directions: _____
Reason for prescription: _____

Continued...

ATTACHMENT C - Continued
Camper Medication Dispensing Form

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

Do Not Mail This Form - Please Bring To Registration!

To be completed by parent or guardian. Please PRINT and Please use blue or black ink only.
(For confidential use by camp staff and health care professionals as needed.)

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:

Over-the-Counter Medication #1: _____
Dosage: _____
Directions: _____
Reason for prescription: _____

Over-the-Counter Medication #2: _____
Dosage: _____
Directions: _____
Reason for prescription: _____

Over-the-Counter Medication #3: _____
Dosage: _____
Directions: _____
Reason for prescription: _____

Sign Here Signature of Physician: _____ Date: _____

I hereby give permission for Camp Downer health care providers to dispense medicine to my child:

Prescriptions listed on front?: ___**Yes** ___**No**

ALL PRESCRIPTION MEDICATION WILL ONLY BE DISPENSED AS PRESCRIBED BY THE DOCTOR.

Non-Prescription medication?: ___**Yes** ___**No**

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury unless otherwise indicated below. Acetaminophen *(Tylenol)*, Ibuprofen *(Advil, Motrin)*, Diphenhydramine antihistamine/allergy medicine *(Benadryl)*, Dextromethorphan cough syrup *(Robitussin DM)*, Sore throat spray, Generic cough drops, Lice shampoo or cream *(Nix or Elimite)*, Antibiotic cream, Calamine lotion, Aloe, Bismuth subsalicylate for diarrhea *(Kaopectate, Pepto-Bismol)*

Please note any Non-Prescription medications the camper should **not** be given:

_____
_____
_____

Sign Here Parent/Guardian Signature: _____ Date: _____

ATTACHMENT D

Camper Comprehensive Physical Form

(To be completed by the camper's physician as needed, see below)
To be completed by parent or guardian. Please PRINT and Please use blue or black ink only.

Do Not Mail This Form-Bring To Registration!

(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 Last Name:_____ Camper First Name:_____

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

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

Sign Here Signature of Physician: _____ Date: _____

ATTACHMENT E

Camper Immunization History Form

All campers must either:

A) attach a printed report of immunizations from their health care provider, or
B) complete this Immunization Form (Attachment E) (Please PRINT in blue or black ink) or
C) complete and attach a Vermont Department Of Health Medical or Religious Exemption Form.

Camp Downer does not accept Philosophical Exemptions.

Do Not Mail This Form-Bring To Registration!

(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 Last Name:_____ Camper First Name:_____

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

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)			

M.M.R. (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)		

VARICELLA (Chicken Pox)

Varicella Disease Date _____, or as indicated below

Varivax #1 Date_____ Varivax #2 Date_____

If you wish to claim a Medical or Religious Immunization, you MUST complete and attach a Vermont Department Of Heath Exemption Form EVERY YEAR. Camp Downer will no longer accept a Philosophical Exemption.

Religious Exemption Form:
http://www.healthvermont.gov/sites/default/files/documents/2016/11/ID_IZ_CCP_Religious_Exemption_SY16-17.pdf

Sign Here Parent/Guardian Signature: _____ Date: _____