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 and Reaction: _____
_____
_____
_____
_____

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

___Chronic Diseases: _____
_____

___Diabetes

___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): _____
_____
_____

List activities in which you do not want your camper to participate: _____
_____
_____
_____

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. 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? _____

Sign Here Parent/Guardian Signature: _____ Date: _____

Continued...

5. Please indicate last medical exam information:
Name of examining physician/clinic or health center:_____
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.

6. Immunizations:
All campers must either:
A) attach a printed report of immunizations from their health care provider, or
B) complete and attach a Vermont Department Of Health Medical or Religious Exemption Form.

Camp Downer Inc. does not accept Philosophical Exemptions.

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

8. 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:_____

9. 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 _____

Continued...

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 / allergies
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: _____

Continued...

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: _____

Continued...

ATTACHMENT C
Camper Medication Dispensing Form

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

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: _____

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: _____

Over-the-Counter Medication #4: _____
Dosage: _____
Directions: _____
Reason for prescription: _____

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

Prescriptions Medication listed above?: ___**Yes** ___**No**

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

Over-the-Counter Medication?: ___**Yes** ___**No**

The following Over-the-Counter 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) for constipation (Miralax)*

Please note any Over-the-Counter Medication the camper should **not** be given:

_____

_____

Sign Here Parent/Guardian Signature: _____ Date: _____