



**Brethren
Woods**

CAMPER Health Information Form

Camper Name: _____
First Middle Last

Preferred Name: _____ Dates of Camp(s): _____

Birth Date: _____ Age at Camp: _____

Male

Female

Area/Group (for camp use only): _____

DIRECTIONS:

1. Please complete pages 1-2 of this form as accurately as possible and **BRING IT WITH YOU** when you come to camp.
2. Attach a copy of **BOTH SIDES** of your insurance card, if appropriate.
3. Be sure to bring all medications listed with you to camp in their **ORIGINAL CONTAINER** with the **ORIGINAL LABEL**.

Contact Information

Home Address: _____
Street City State Zip Code

Phone Number(s): Cell _____ Home _____ Work _____

Emergency Contact to be contacted in case of illness or injury:

Name: _____ Relationship to Camper: _____

Preferred Phone Number(s): Cell _____ Home _____ Work _____

Allergies – Persons with food allergies should complete a Food Allergy & Special Diet Questionnaire for our Food Service Staff.

- No known allergies.
- Allergies to food, medicine, environment (insect stings, hay fever, etc.), or other. **Describe in detail below.**

| Allergen | Severity and Time Till Reaction | Reaction Experienced | Management Required | Ability of Camper to Manage Allergy & Threats |
|----------|---------------------------------|----------------------|---------------------|---|
| | | | | |
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Diet/Nutrition – Persons with intolerances should complete a Food Allergy & Special Diet Questionnaire for our Food Service Staff.

- Eats a regular diet.
- Eats a regular vegetarian diet.
- Eats a diabetic diet.
- Lactose intolerant.
- Gluten intolerant.
- Other diet. **Describe in detail below.**

Activity Restrictions

- I have reviewed the program and activities of the camp and feel the camper can participate **WITHOUT** restrictions.
- I have reviewed the program and activities of the camp and feel the camper can participate **WITH** the following restrictions or adaptations. **Describe in detail below. Attach sheets with additional information if needed.**

Anything Else? – Please provide any additional information in the space below that you think important or that may affect the time at camp for this camper. Attach sheets with additional information if needed.

Health Center Medications – Please cross out any items that the camper should NOT be given.

The following non-prescription medications (name brand or generic) MAY be stocked in the camp Health Center and are available for use on an as needed basis to manage illness and injury. Campers DO NOT need to bring these medications with them to camp unless prescribed and/or needed for regular use.

- | | |
|--|--|
| Acetaminophen (Tylenol) / Ibuprofen (Advil, Motrin) | Pseudoephedrine decongestant (Sudafed) |
| Phenylephrine decongestant (Sudafed PE, Cold/Sinus) | Guaifenesin cough syrup (Robitussin, Robitussin CF) |
| Antihistamine/allergy medicine | Dextromethorphan cough syrup (Robitussin DM) |
| Diphenhydramine antihistamine/allergy medication (Benadryl) | Generic cough drops |
| Sore throat spray | Antibiotic cream |
| Calamine lotion (Caladryl) | Hydrocortisone cream |
| Laxatives for constipation (Milk of Magnesia, Ex-Lax, suppositories) | Aloe, Aloe vera |
| Antacid (Tums) | Bismuth subsalicylate for diarrhea (Imodium, Pepto-bismol) |
| Zanfel for poison ivy | Midol |
| Epi-Pen (regular, junior) | Sunscreen |

Camper Medications – A “medication” is any substance a person takes to maintain and/or improve their health. This includes prescription and over-the-counter substances, including vitamins and natural/health remedies.

- This camper will NOT bring any medications to camp.
- This camper WILL bring the following medications to camp to be managed by themselves or the camper’s parent/guardian who will be on-site at camp. *We understand that all medications must be stored in a secure area under lock and away from minors (ex. locked vehicle) except for emergency medications (ex. Epi-Pen, inhaler, insulin, etc.) when in the controlled possession of the person responsible for administering them.*
- This camper WILL bring the following medications to camp to be managed by camp staff. *Attach sheets with additional information if needed. Be sure to bring all medications listed with you to camp in their ORIGINAL CONTAINER with the ORIGINAL LABEL showing the camper name, prescribing physician (if applicable), name of the medication, dosage, frequency, and how the medication is to be given.*

| Medication Name | Date Started | Reason for Taking | When it is Given | Amount or Dose Given | How It is Given |
|-----------------|--------------|-------------------|--|----------------------|-----------------|
| | | | <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other: _____ | | |
| | | | <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other: _____ | | |
| | | | <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other: _____ | | |

Acknowledgement and Authorization for Health Care

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted. I understand that first aid supplies and equipment, including an AED, are available on-site at camp. For all-adult or family programs, I understand that adult participants retain primary responsibility for managing their health status, as well as the health status of any minors under their care. A camp staff member with at least basic first aid and CPR/AED certification from a nationally recognized provider will be available to help with emergent health needs. All injuries and illnesses occurring on-site or during a camp program should be reported to this designated staff member. For programs for minors attending camp without a parent or guardian present, I give permission to the camp healthcare provider(s) to provide routine health care, including administering medications. The camp generally does not contact parents/guardians or emergency contacts if campers are seen by the camp healthcare provider for routine problems (e.g., skinned knees, sore throat, headache) that do not require a physician referral. This includes overnight stays in the health center. The decision to consult parents/guardians or emergency contacts in these situations is determined on a case-by-case basis by our healthcare provider. I understand I must attach a letter to this form if I want the camp to follow a practice different from what is described. In case of an emergency, the camp healthcare provider will make every effort to reach the emergency contacts by phone, using the numbers provided on this form, if the camper listed has need for out-of-camp healthcare, but the camp cannot promise that it will be successful in reaching these persons. If these persons cannot be reached in an emergency, I give permission to the physician selected by the camp to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this camper. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of me or my child for both routine health care and emergency situations. In case of an emergency, adult participants may provide their own transportation for themselves or minors under their care or the local emergency medical services may be contacted. It typically takes 20-30 minutes for emergency medical services to arrive at camp. The closest hospital and pharmacy are approximately 15 miles from camp. I give permission to the camp to arrange necessary related transportation for me or my 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 me or my child’s health record from providers who treat me or my child and these providers may talk with the camp staff about my or my child’s health status.

Signature of Custodial Parent/Guardian or Adult Camper: _____

Relationship to Camper: _____ **Date:** _____

