



First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

# 2018 CAMPER INFORMATION & HEALTH FORM

The purpose of this health form is to assist Stoney Creek Health Care Staff in identifying appropriate care. The information in this form will only be available to staff who will be working with your camper. This health form is required for camp attendance and must be completed by the camper's parent/guardian. Health forms from last year are not valid for this year.

## CAMPER INFORMATION (Ages 9-17)

Date of Birth: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
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First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

## EMERGENCY INFORMATION (lives with Camper)

Custodial Parent(s)/Guardian(s): \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**BACKUP EMERGENCY INFORMATION\*\*** Required- must be someone who does not live with the camper. Please provide contact information of other person who know your camper and with whom can consult if we cannot reach you. We assume you have spoken with these individuals and that they are willing to assist should the need arise.

Name of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## CAMPER HEALTH INFORMATION

### PHYSICIAN INFORMATION

Name of camper's Physician: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Name of camper's Dentist/ Orthodontist: \_\_\_\_\_ Office Phone: \_\_\_\_\_

### INSURANCE INFORMATION

Is the camper covered by family medical insurance?	<input type="checkbox"/> YES <input type="checkbox"/> NO
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Insurance Carrier/Plan Name: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Policy Number: \_\_\_\_\_

**\*\*\*If no insurance, please complete the Insurance Wavier Form**

** Required ** Please provide the month and year for the camper's last tetanus booster.	<b>Tetanus Booster or Last DTP</b> Month: _____ Year: _____
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### IMMUNIZATIONS

Camper currently attends school and is current on all required immunizations. \_\_\_\_ Yes \_\_\_\_ No

Camper is not enrolled in a school system. *If not enrolled in school, please attach a copy of current immunization record to this form.*

### ALLERGIES NOTE: WE ARE NOT PEANUT FREE.

We will make every attempt to communicate concerns regarding peanut allergies but do not guarantee zero exposure.

This camper has **NO** known allergies.

This camper has the following allergies: **(Please list all allergies and provide information about reaction and treatment**

**Medication Allergy:** \_\_\_\_\_

**TREATMENT:** \_\_\_\_\_

**Food Allergy:** \_\_\_\_\_

**TREATMENT:** \_\_\_\_\_

**Other Allergy (includes plant, animal, etc.):** \_\_\_\_\_

**TREATMENT:** \_\_\_\_\_

Please circle the session the camper will be attending and the organization which they will be attending camp with.

Session: 1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10 / 11 / 12 / 13

Organization Name: \_\_\_\_\_



First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

# 2018 CAMPER INFORMATION & HEALTH FORM

## ADDITIONAL INFORMATION

Please list any additional information that would help our medical staff when caring for your camper:

## MEDICAL CONCERNS

\*Please call (979) 733-9022 to contact the Stoney Creek Nurse if you need to discuss your child's health concerns.

- This camper has NO long-term health concerns and is capable of full participation in the camp program at Stoney Creek Ranch.
- This camper has the following health concern(s): (Check all that pertain to this camper and provide information about supportive health care.)
  - ADHD/ ADD     Depression     Hearing Loss     Kidney Disease     Ear Infections     Migraine Headaches     Anorexia, Bulimia (eating disorders)
  - SERVE Allergic Reactions / To what? \_\_\_\_\_ Describe Reactions: \_\_\_\_\_
  - Asthma / Date of last episode \_\_\_\_\_ Will an Inhaler be used at Camp? Yes or No
  - Diabetes Do you take Insulin? Yes or No
  - Any other illnesses such as Crohn's Disease, Anemia, Seizures, Tourette's, etc. \_\_\_\_\_

Please list ALL prescription medication, over-the-counter and non-prescription drugs taken routinely. Fill in the blanks completely. All drugs must remain in the original container. All prescription medications must be in a pharmacy-labeled container with the camper's name on it. Loose pills and samples will not be accepted.

Bring ONLY enough medication to last 5 days. Empty bottles will be returned to your Camper's Group Leader.

- This camper does NOT take any medications on a regular basis.
- This camper takes routine medication as follows: (Use a separate sheet if necessary.)

<b>Medication 1</b>	<b>Medication 3</b>
Reason _____	Reason _____
Dose taken _____	Dose taken _____
When taken each day _____	When taken each day _____
<b>Medication 2</b>	<b>Medication 4</b>
Reason _____	Reason _____
Dose taken _____	Dose taken _____
When taken each day _____	When taken each day _____

The information given in this form is complete and accurate to the best of my knowledge. I hereby give my permission for my camper to participate in all camp activities.

1. I hereby give my permission for Stoney Creek to use or disclose Protected Health Information (PHI) to necessary staff and any volunteer or paid health care professional or facility for diagnosis, treatment, health care needs, emergency medical care or coverage information for my camper.
2. I hereby give my permission to licensed Stoney Creek medical/nursing staff, volunteer physicians and volunteer licensed medical/nursing staff to administer prescribed medication, provide health care, and seek emergency medical care. I hereby give my permission to Stoney Creek Ranch to provide or seek transportation to medical facilities for my camper.

In case of emergency where I can't be contacted, I hereby give permission to the physician selected by Stoney Creek to secure and administer proper treatment, hospitalize, order injections, order anesthesia and/or surgery for my camper.

### 3. I HEREBY GIVE MY PERMISSION FOR LICENSED Stoney Creek MEDICAL/NURSING STAFF AND VOLUNTEER LICENSED MEDICAL/NURSING STAFF TO ADMINISTER OVER-THE-COUNTER MEDICATIONS TO MY CAMPER AS NEEDED.

4. I understand that the Nurse Manager and/or the Camp Director reserves the right to send home a camper whose medical condition becomes unmanageable and/or places the camper or Stoney Creek at risk in the Camp environment.
5. I agree to make Stoney Creek aware of all known medical issues regarding my camper's health and will update this form with additional issues that may occur between now and the start of camp.

## PARENT/GUARDIAN SIGNATURE REQUIRED HERE:

DATE: