2015 Camp Sertoma Health Form

Health Form MUST be returned to camp by June 1, 2015

Camp Sertoma
1620 Mary Fawcett Memorial Dr
East Gull Lake, MN 56401
218-828-2344 ,VP 218-297-0159

Camper Name_____
Age_____ Birthday_____
Grade completed Spring 2015_____ Gender: Male Female

Parent/ Guardian:
_____

Home Phone/ VP
_____

Home Address
_____

City /State/ Zip
_____

If parents/ guardian is not available in an emergency, notify:

1.) Name: _____
Relationship_____

Home #_____ Cell#_____
Work#_____

2.) Name: _____
Relationship_____

Heath Care Providers:

Name Camper's Primary Doctor(s) _____
Phone_____

Name of Dentist_____
Phone_____

Parent/Guardian Authorization: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to Camp Sertoma to provide routine health care, administer prescription medications, and seek emergency treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to Camp Sertoma to arrange necessary related transportation for me/my child.

We practice safety at all times, to the best of our ability; however, participation in camp life and activities has inherent risks and injuries sometimes do occur. With enrollment, parents acknowledge and assume financial responsibility for medical expenses and agree to hold harmless Confidence Learning Center, Sertoma Inc., its employees, and agents against any and all claims, damages and injuries.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Camp Sertoma to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Should my child need to leave camp for behavioral or medical reasons I agree to pick up or make arrangements for transportation within a timely matter or may be charged an additional fee for my child's care.

Signature of parent/guardian _____

Printed Name_____ Date_____

I also understand and agree to abide by any restrictions placed on my participation in camp activities
Signature of minor camper_____ Date_____

*If for religious reasons, you cannot sign this, contact Camp Sertoma for a legal waiver that must be signed for attendance.

Billing Information for Health Care:

Insurance Company: _____ Phone_____

Claims Address_____Phone_____

Policy number for your child_____

Parent/ guardians are financially responsible for health care given by an out-of –camp provider for medications, illness treatment, pre-existing conditions etc.

* Photocopy of front and back of health card must be attached to this form*

GENERAL QUESTIONS (Explain "yes" answers below.)

Has/does the participant:

1. Had any recent injury, illness or infectious disease?
_____Yes _____No
2. Have a chronic or recurring illness/condition?
_____Yes _____No
3. Allergy to latex?
_____Yes _____No
4. Ever been hospitalized?
_____Yes _____No
5. Ever had surgery?
_____Yes _____No
6. Have frequent headaches?
_____Yes _____No
7. Has any known allergies?
_____Yes _____No
8. Anaphylaxis (requires and Epi-pen for allergies)?
_____Yes _____No
9. Ever had a head injury?
_____Yes _____No
10. Ever been knocked unconscious?
_____Yes _____No
11. Wear glasses, contacts or protective eyewear?
_____Yes _____No
12. Wear hearing aids or cochlear implant?
_____Yes _____No
13. Ever had frequent ear infections?
_____Yes _____No
14. Ever passed out during or after exercise?
_____Yes _____No
15. Ever been dizzy during or after exercise?
_____Yes _____No
16. Ever had seizures?
_____Yes _____No
17. Ever had chest pain during or after exercise?
_____Yes _____No
18. Ever had high blood pressure?
_____Yes _____No
19. Ever been diagnosed with a heart murmur?
_____Yes _____No
20. Ever had back problems?
_____Yes _____No
21. Ever had problems with joints (e.g. knees, ankles)?
_____Yes _____No
22. Have an orthodontic appliance being brought to Camp?
_____Yes _____No
23. Have any skin problems (e.g. itching, rash, acne)?
_____Yes _____No
24. Have diabetes?
_____Yes _____No
25. Have asthma?
_____Yes _____No
26. Have mononucleosis in the past 12 months?
_____Yes _____No
27. Has problems with diarrhea/constipation?
_____Yes _____No
28. Have problems with sleepwalking?
_____Yes _____No
29. If female, have an abnormal menstrual history?
_____Yes _____No
30.If female and not started menstruation, has she been told what to expect?
_____Yes _____No
31. Have a history of bed-wetting?
_____Yes _____No
32. Have any special physical needs?
_____Yes _____No

Please explain any "yes" answers, noting the number of the questions:

_____

_____

_____

Mental, Emotional and Social Health

33. This camper has been diagnosed with Attention Deficit Disorder (ADD) or ADHD
_____Yes _____No

34. Ever had emotional difficulties for which professional help was sought?
_____Yes _____No

35. This camper had a psychiatric diagnosis such as depression, OCD, Panic/Anxiety disorder, eating disorder
_____Yes _____No

36. Have any special behavioral needs?*If "Yes" Please attach written information for behavior management
_____Yes* _____No

37. This camper has had a significant life event that continues to affect the camper's life* if" yes" please attach written information about the event- death of a loved one, family change, survived disaster, etc.
_____Yes* _____No

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the Camp should be aware. (Use additional paper if needed)

_____

_____

_____

_____

_____

Medications being taken

"Medications" is any substance a person takes to maintain and/or improve his or her health and includes vitamins and homeopathic remedies Please list ALL medications taken routinely. ***Bring ONLY enough medication to last the entire time at camp***. **Keep it in the ORIGINAL packaging/bottle that identifies the prescribing physician**

_____This Camper will NOT be taking any medication while at Camp Sertoma

_____This Camper will take the following medications(s) while attending Camp Sertoma.

Name of Medication and dosage	Reason for Taking it	When to be given	Date Started
		○ Breakfast ○ Lunch ○ Dinner ○ Bedtime ○ Other_____	
		○ Breakfast ○ Lunch ○ Dinner ○ Bedtime ○ Other_____	
		○ Breakfast ○ Lunch ○ Dinner ○ Bedtime ○ Other_____	

Attach additional pages for more medication.

Over the Counter Medications

The following generic medications are stocked in our Nurse's office and are used to manage illness and injuries that may occur while your child is at Camp Sertoma**. Cross out those that SHOULD NOT be given.**

Acetaminophen (Tylenol)	Ibuprofen (Advil, Motrin)	Antibiotic Ointment or Cream	Benadryl (lotion)
Benadryl (oral)	Cough Drops	Cough Syrup	Caladryl (Poison Ivy Lotion)
Bismuth (Pepto – Bismal)	Tums	Hydrocortisone Cream	Benzocaine (Insect Bite Spray)
Solocaine (Sunburn Spray)			

Parent/Guardian Signature_____ **Date**_____

RESTRICTIONS
The following restrictions apply to this individual.

Dietary

_____Does not eat red meat	_____Does not eat pork	_____Gluten Free Diet
_____Does not eat dairy products	_____Does not eat seafood	_____ Lactose Intolerant
_____Does not eat poultry	_____Does not eat eggs	_____ Other (Describe)

Explain any restrictions to activity (e.g. what cannot not be done, what adaptations or limitations necessary)

_____

_____

*Immunization History:

Provide the month and year for each immunization or attach a copy of your child's clinic/school immunization record. Starred (*) immunizations must be current. **Families must provide information each year for child to attend**.

Immunization	Date: Month(s) & Year(s)	Immunization	Date: Month(s) & Year(s)
Tetanus Booster* (within 10 years)		Varicella (Chicken Pox)	
MMR * (Measles, Mumps Rubella)			
Polio Series*		Hepatitis B	
Pertussis Booster		Hepatitis A	

You must have a physician fill out and sign "PHYSICAL EXAMINATION FORM" or have the physician's office fax the following information to Camp Sertoma (218) 828-2618 on a separate form. Health Exam must be no more than 24 months prior attending Camp. **This information MUST be at camp before June 1, 2015**
*Date of Health Examination
*Signature and date from physician
*Current or on-going treatments or medications
*Any physical conditions requiring restrictions while at Camp Sertoma, and list restrictions.
* Questions please contact Jen or Emily, jen@campconfidence.com or Emily@DreamsAndInspirations.com (218)828-2344 OR VP 218-297-0159

PHYSICAL EXAMINATION FORM 2015

(This form must be completed by licensed medical personnel)

Camp Sertoma
1620 Mary Fawcett Memorial Drive
East Gull Lake, MN 56401
218-828-2344 OR 218-297-0159
Fax 218-828-2618

The information on this form is not part of the camper acceptance process, but is gathered to assist us in identifying appropriate care. A physical exam must be completed by licensed medical personnel at least every 24 months prior to attending Camp Sertoma.

Name of Camper_____ Birth Date_____

Health Care Recommendations by Licensed Medical Personnel

I have examined the above camp participant on (date) _____

Weight_____ Height_____

This camper is independent in toileting, bathing and other personal hygiene ( ) Yes ( ) No

In my opinion, the above applicant **( ) is** **( ) is not** able to participate and work in an active camp program

The applicant is under the care of a physician for the following condition(s)

_____

_____

Recommendations and Restrictions at Camp

Treatment to be continued at camp: _____

_____

Medications to be administered at Camp: (name, dosage, frequency):_____

_____

Any medical prescribed meal plan or dietary restrictions: _____

_____

Known Allergies: _____

_____

Descriptions of any limitations or restrictions on camp activities:

_____

_____

Additional information (behavioral, physical, emotional or mental health) for health care staff: _____

_____

Signature of Licensed Medical Personnel_____Date_____

Printed_____ Title_____

Address_____ Phone: _____