MEDICAL INFORMATION FOR YOUTH PARTICIPANTS

INSTRUCTIONS: Complete the entire form and bring with you to 2017 Senior Leader Lab - POWER Camp.

District 2 County _____ Program Date: 06/30/2017 **to** 07/02/2017

Camper's Name _____ Male ☐ Female ☐
FIRST LAST

Address _____ Date of Birth _____ Grade (2016-17 year) _____

City _____ State ___ Zip _____ **Camper's Social Security #:*** _____

Parent or Guardian Name _____ **Daytime Phone** _____

Address_____ **Evening Phone** _____

City _____ State ___ Zip _____ **Cell Phone** _____

EMERGENCY CONTACTS: (if parent or guardian cannot be reached)

Name _____ Daytime Phone _____ Evening Phone _____

Name _____ Daytime Phone _____ Evening Phone _____

Name of Family Physician: _____ Phone _____

Medical Insurance Carrier: _____ Policy #: _____

ACTIVITY RESTRICTIONS:

Is there any reason to restrict full activity, including hiking, swimming or other strenuous play? ☐ Yes ☐ No

IF YES, describe in detail:_____

_____ (Use a separate page if needed.)

MEDICATIONS: – Please list **ALL** medications, including over-the-counter or nonprescription drugs and supplements. Send enough medication to last the entire time at camp. Keep all medications in the original packaging or bottle that identifies the prescribing physician, name of medication, dosage and frequency. Use an additional sheet if necessary.

Name of Medication	Reason for Taking
1.	
2.	
3.	
4.	

MEDICATION ALLERGIES: – Please list **ALL** medications, including over-the-counter or nonprescription drugs and supplements your child is allergic to. Use an additional sheet if necessary.

Name of Medication	Name of Medication
1.	3.
2.	4.

PLEASE CHECK "over-the-counter" medication(s) which camp personnel may administer as deemed necessary:

- ☐ Acetaminophen (Tylenol)
- ☐ Ibuprofen (Motrin)
- ☐ Pepto Bismol
- ☐ Rolaids
- ☐ Neosporin/Cortisone cream
- ☐ Robitussin/Benadryl
- ☐ Immodium AD
- ☐ Calamine/Caladryl
- ☐ **Any As Needed**
- ☐ **NO, DO NOT ADMINISTER ANY "over-the-counter" medications to my child.**

_____**PLEASE INITIAL.**

*medical facilities may require SSN to provide treatment

IMMUNIZATION HISTORY (MANDATORY) Please give **DATE OF LATEST IMMUNIZATION** for:

_____ Tetanus	_____ Haemophilus influenza B	_____ Varicella (chicken pox)
_____ Diphtheria	_____ Mumps	_____ DTP
_____ Polio	_____ Hepatitis B	_____ Small Pox
_____ TB Mantoux	Test - Result: ☐ Positive ☐ Negative	

HEALTH HISTORY: (Please check any of the following that apply)

☐ Frequent Ear Infections	☐ Heart Defect / Disease
☐ Convulsions	☐ Diabetes: ☐ Type I (juvenile) ☐ Type II
☐ Hypoglycemia	☐ Bleeding/Clotting Disorders

☐ Other_____

ALLERGIES: (Please Check any of the following that apply)

☐ Hay Fever ☐ Poison Ivy/Oak ☐ Insect Stings ☐ Other (please list) _____

OPERATIONS OR SERIOUS INJURIES: (List along with approximate date): _____

_____

_____

CHRONIC OR RECURRING ILLNESS:_____

_____

_____

ANY OTHER INFORMATION: _____

_____

_____

PLEASE ATTACH AN ADDITIONAL SHEET if necessary to provide any **additional medical information** or additional information about the participant's behavior and physical, emotional or mental health about which the camp should be aware.

☐ **ADDITIONAL INFORMATION ATTACHED** ☐ **NO ADDITIONAL INFORMATION**

PERMISSION TO PROVIDE NECESSARY TREATMENT OR EMERGENCY CARE

I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

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

_____ _____

Parent or Guardian Signature **Date**