

2017 Camp Recky

Camper Health Information

Parents/Guardians: Please follow the instructions below. Attach additional information as needed. This form shall be completed and returned to Camp Recky prior to the camper's first day of attendance and updated as needed.

1. Complete all pages (4) of this form and make a copy for your records.
2. Send the original, signed form to Camp Recky by May 1, 2017.

Mail completed form to: Camp Recky
337 Annie & John Glenn Ave.
B149 RPAC
Columbus, OH 43210
agegroup@osu.edu

Camper Information

Camper's Full Name: _____	Date of Birth: _____	Age on arrival at camp: _____	Grade _____
completed during 2016-2017 school year: _____		School District: _____	
<input type="checkbox"/> Male <input type="checkbox"/> Female	Camper will attend camp from: _____ (mth/day/year) to _____ (mth/day/year)		
Home Address: _____			
City: _____	State: _____	Zip: _____	Home Phone: _____
Circle your preferred shirt size:	Youth S	Youth M	Youth L Adult S Adult M Adult L

Contact Information

Parent/Guardian with legal custody to be contacted in case of illness or injury:

Parent/Guardian Name: _____ Relationship to child: _____

Home Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____

Work/School Name: _____ Work/School Address: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

Email address: _____

Where can you be reached while your child is at camp? _____

Second Parent/Guardian:

Parent/Guardian Name: _____ Relationship to child: _____

Home Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____

Work/School Name: _____ Work/School Address: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

Email address: _____

Where can you be reached while your child is at camp? _____

Emergency Contact Information

Parents cannot be listed as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness if you cannot be reached. Any person listed should be able to assist in contacting you and at least one person listed must be within one hour of the camp and able to take responsibility for the camper in case you cannot be contacted.

Name: _____ Relationship to Child: _____

City: _____ State: _____ Phone: _____

Other numbers for Emergency Contact: _____

Name: _____ Relationship to Child: _____

City: _____ State: _____ Phone: _____

Other numbers for Emergency Contact: _____



Health Insurance/Physician Information

Insurance Company: _____ Phone: _____ Policy #: _____

Camper's Primary Doctor: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Camper's Dentist: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Allergies, Special Health or Medical Conditions, and Food Supplements:

Fill in this section accurately and completely. Please note that if your child has a current health or medical condition requiring camp staff to monitor the condition, provide treatment, care or to give medication, you will also be required to fill out a Medical/Physical Care Plan.

Please Note: Camp Recky will receive, approve, and administer medication to children when the medication is needed for chronic or life-threatening conditions (such as asthma treatments or emergency allergy medication). Other medications, such as antibiotics, which can be administered outside of camp hours, should be cared for by parents rather than the camp staff. If your child will need any medication while at camp you will be required to complete a request for medication administration form.

1. Does your child have any allergies? (check all that apply) ☐ None ☐ Food ☐ Medication ☐ Environmental

Please list and explain: _____

Does your child's allergy/allergies require camp staff to monitor child for symptoms, take action if a reaction occurs or give emergency medication to your child? (check one)

☐ No ☐ Yes

If yes, please explain: _____

2. Please indicate any of the following that apply to your child:

<input type="checkbox"/> Allergy to a medicine, food, animal, or insect toxin	<input type="checkbox"/> ADD or ADHD	<input type="checkbox"/> Contact lenses	<input type="checkbox"/> Bleeding disorders
<input type="checkbox"/> Any condition that may require special care, medication, or diet	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Dentures
	<input type="checkbox"/> Seizures	<input type="checkbox"/> Fainting spells	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> Heart trouble		

3. Is your child currently using any medication (prescription or over-the-counter), food supplement, or medical food (such as electrolyte solution)? (check one) ☐ No ☐ Yes (please explain) _____

If yes, please list medication, dosage, and time administered. _____

4. List any history of hospitalization, outpatient surgery, or previous health condition that would be needed to assist the staff or medical personnel in an emergency situation: _____

5. List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits or special routines.

This information should not be medical or health related, as that information should be included in the above questions.



6. Do you have any suggestions on successful behavior management techniques for your child that staff should be aware of?

7. Does your child have any additional 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. (Please describe). _____

Immunization History

Provide the month and year for each immunization. Starred (*) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable, please attach to this form.

Immunization	Dose 1 (mo/yr)	Dose 2 (mo/yr)	Dose 3 (mo/yr)	Dose 4 (mo/yr)	Dose 5 (mo/yr)	Most recent (mo/yr)
Diphtheria, Tetanus, Pertussis (DTaP or TdaP)*						
Tetanus booster (dT or TdaP)*						
Mumps, Measles, Rubella (MMR) *						
Polio (IPV)*						
Haemophilus Influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (Chicken Pox)	<input type="checkbox"/> Had chicken pox Date: _____					
Meningococcal Meningitis (MCV4)						

In case of emergency or illness, every effort will be made to contact the parents or guardians. In the event that contact cannot be made, I hereby grant permission for physicians, dentists, or other licensed health care providers and their designees employed by The Ohio State University to administer outpatient medical, surgical, or dental services as appropriate, or necessary antigens or other injections, to perform emergency procedures as necessary, or to refer to duly licensed medical personnel when indicated. I understand and accept any and all risks that may be associated with my child not having received all doses of immunizations for which their age makes them eligible. By signing below, I also acknowledge that during the course of an outbreak of any of the diseases listed within the "Immunization History" section for which my child is not immunized that my child may be subject to exclusion from camp for the duration of the outbreak for health and safety reasons.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

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Camper Pick Up Authorization

If you need to have anyone other than a parent/guardian pick-up your child, a completed and signed Pick-up/Release Authorization Form must be submitted to the Community Programs office prior to the camper's departure from camp. For everyone's safety we cannot accept phone messages or notes provided by unauthorized individuals picking up campers after their sessions. For your child's protection we cannot make any exceptions to this policy. Please, only one camper per form. Please complete additional forms for additional campers.

Authorized Person(s) for Pick Up:

As legal, custodial parent/guardian of (camper's full name) _____, I (parent/guardian name), _____, give the following individuals my permission to pick-up my child:

- | | |
|---------------|-------------|
| 1. Name _____ | Phone _____ |
| 2. Name _____ | Phone _____ |
| 3. Name _____ | Phone _____ |
| 4. Name _____ | Phone _____ |
| 5. Name _____ | Phone _____ |

I understand that neither Camp Recky nor any of its representatives can be held responsible for my child once they are under the supervision of the individual listed above. For the safety of the camper, Camp Recky representatives may ask the individual listed above to verify their identity by showing an official picture ID (drivers license, ID card, current passport, etc.) prior to releasing the camper.

Legal Custodial Parent/Guardian Signature: _____ Date: _____

Un-authorized Person for Pick Up:

Please notify camp in writing if there is someone who should not be allowed to pick-up your child. If a family member is not permitted to pick-up your camper, a copy of the court order must be forwarded to the Camp's attention. The following are legally unable to pick up my child. A copy of a court order is enclosed.

Name _____	Relationship _____
Name _____	Relationship _____
Name _____	Relationship _____

Legal Custodial Parent/Guardian Signature: _____ Date: _____

