River Camp Session #____ Session Dates _____

HEALTH RECORD

This form is to be completed by parent/guardian of minors or by adult staff member

Name_____
Address_____
Home Phone #_____
Date of Birth_____

Parent/ Guardian (or Spouse)'s Name_____
Address_____
Home Phone #_____
Cell Phone #_____
Work Phone #_____

Second Parent/ Guardian's Name_____
Address_____
Home Phone #_____
Cell Phone #_____
Work Phone #_____

Emergency Contact (other than Parent or Spouse)/ Phone #_____
Emergency Contact (other than Parent or Spouse)/ Phone #_____

Physician's Name_____
Address _____
Phone #_____

Health Insurance Carrier_____
Policy #_____
Address_____
Phone #_____

Will the camper/ staff member need to take any prescribed medication during camp hours? _____
If yes, please complete the "Authorization to Administer Medication" form.

Does the camper/ staff member have any allergies? Please list._____
_____

Does the camper/ staff member have any health conditions or impairments which may affect his/ her activities while attending the camp? Please describe._____
_____

Please enclose a copies of the following, signed by a licensed health care provider or designee:

1. **Camper/staff member's CERTIFICATE of IMMUNIZATIONS**
2. **Report of a PHYSICAL EXAMINATION conducted during the preceding 24 months**
3. **A HEALTH HISTORY**

This medical history is correct so far as I know. AUTHORIZATION FOR TREATMENT: I, hereby authorize River Camp counselors to provide emergency medical care for me/ my child if deemed necessary. I also authorize a River Camp counselor to administer the above-mentioned medications as directed on the label.

Signature of Parent/ Guardian or Adult Staff_____ **Date**_____

This side to be completed by Licensed Health Care Provider

A physician-provided form may be submitted in place of this side if all requested information is included.

HEALTH HISTORY INFORMATION

O Diabetes _____
O Asthma* _____
O Seizures _____
O Heart Disorder _____
O Mood or Mental Health Disorder _____
O ADD or ADHD _____
O Hay Fever _____
O Insect Sting Allergy** _____
O Food Allergy** _____
O Medication Allergy _____
O Poison Ivy Allergy_____

* If a camper has asthma, include a copy of the camper's asthma action plan.
**If a camper has an anaphylactic allergy, include a copy of the camper's allergy action plan.

Explain "YES" answers to any of the above_____
_____
_____
_____

Operations or serious injuries (list dates): _____
Disability or chronic recurring illness: _____
Any specific activities to be encouraged or limited by physician's advice: _____

HEALTH EXAMINATION BY LICENSED HEALTH CARE PROVIDER

I have examined this applicant. Dr. _____ Date: /_____/_____

In my opinion, the above's condition O Does O Does not preclude his/her participation in an active camp program.

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

Current Treatment (include current medications):_____
_____
_____

Explanation of any reported loss of consciousness, convulsion, or concussion: _____
_____
_____
_____

Does applicant have epilepsy? O Yes O No Does applicant have diabetes? O Yes O No

RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP

Any treatment to be continued at camp: _____
_____
Any medication to be administered at camp (specify dosages): _____
_____
Any medically prescribed meal plan or dietary restrictions: _____
_____
Any allergies (food, drugs, plants, insects, etc): _____
_____
Additional health information: _____
_____

Signature of Licensed Health Care Provider _____ Print name _____
Address_____
Phone # _____
Form Completed by:_____ Date _____/_____/_____