



MOUND RIDGE CAMP SUMMER CAMP

Section I Health Form: To be filled out by Parent or Guardian

Campers Name _____ Gender _____ Birthdate _____
Last First MI

Home Address _____
Street City State Zip

Home Telephone # _____

Please inform us in writing of any travel plans you have during your child's stay at Mound Ridge. Please attach phone numbers, local relative names and number, and/or any other information that would assist us in contacting you in case of emergency. Thank You

Section II – Insurance Information – Is the participant covered by family medical/hospital insurance? _____

If so, indicate carrier or plan name _____ Group# _____

Insurance Company Phone Number _____ Name of Insured _____

Policy Holder's SS# or Insurance ID # _____ Relationship to participant _____

Address for Claims _____

Please attach a copy of both sides of your insurance card to this form. Thank You.

Section III – Health History – To Be Filled out By Parent/Guardian

Allergies: ___Food ___Poison Ivy ___Hay Fever ___Insect Stings ___Penicillin/Other Drugs ___Other

Please list and describe allergies, reactions, and treatment below:

Physical activities at camp to be limited or encouraged: _____

Dietary modifications: _____

For females, has she menstruated? ___Yes ___No If not, has she been told about it? ___Yes ___No

List all medications, including over-the-counter drugs, currently taken by the camper ___This camper takes no Medications

Medication	Dosage	Reason for taking
_____	_____	_____
_____	_____	_____
_____	_____	_____

All medications (including non-prescription and over-the-counter drugs, inhalers, vitamins and ointments) will be registered with Director upon check-in. Medications must be in their original labeled container that identifies the child's name, prescribing physician (if a prescription drug), name of the medication, dosage, and frequency of administration. Please bring enough medication to last the entire time at camp. Thank you.

Section II

Has the participant ever/does currently/is prone to:

	Yes	No		Yes	No
1. Recent injury, illness or infectious disease.....	___	___	17. Had psychiatric counseling.....	___	___
2. Chronic or recurring illness/condition.....	___	___	18. Back problems.....	___	___
3. Been hospitalized.....	___	___	19. Joint problems (e.g. knees, ankles).....	___	___
4. Had surgery.....	___	___	20. Have an orthodontic appliance to bring to camp.....	___	___
5. Fractures.....	___	___	21. Skin problems (e.g. itching, rash, acne).....	___	___
6. Frequent headaches.....	___	___	22. Diabetes.....	___	___
7. Had a head injury.....	___	___	23. Asthma.....	___	___
8. Been knocked unconscious.....	___	___	24. Had mononucleosis in the past 12 months.....	___	___
9. Wear glasses, contacts or protective eyewear...	___	___	25. Had problems with diarrhea/constipation.....	___	___
10. Ear infections.....	___	___	26. If female, have an abnormal menstrual history	___	___
11. Passed out during or after exercise.....	___	___	27. Nightmares/Night terrors.....	___	___
12. Ever been dizzy during or after exercise.....	___	___	28. Sleepwalks.....	___	___
13. Seizures.....	___	___	29. Ever had an eating disorder.....	___	___
14. Chest pain during or after exercise.....	___	___	30. Requires and/or wears a Medic Alert ID.....	___	___
15. High blood pressure.....	___	___	31. Homesickness.....	___	___
16. Heart murmur.....	___	___	32. Stomachaches.....	___	___
			33. Have a history of bedwetting.....	___	___

Please explain any "yes" answers, noting the number of the questions. Attach extra page if necessary:

Section III

Immunization History – This information will assist hospital staff in the event of an emergency. If possible, simply attach a copy of your child's shot records.

Please list dates of initial series and latest boosters

DPT #1 _____ DPT#2 _____ DPT#3 _____ DPT#4 _____ DPT#5 _____
 MMR _____ OPV#1 _____ OPV#2 _____ OPV#3 _____ OPV#4 _____
 HBPV _____ Date of Latest Tuberculin Test _____ /Reaction _____
 Tetanus _____ Hemophilia _____ Influenza B _____
 Hepatitis B _____
 Varicella (chicken pox) _____
 BCG _____

Which of the following has the participant had?

- ___ Measles
- ___ Chicken Pox
- ___ German Measles
- ___ Mumps
- ___ Tuberculosis
- ___ Hepatitis
- ___ Rheumatic Fever

Section IV – Medical Authorization and Waiver – Must be signed by Parent of Guardian and notarized.

I give permission for my child to engage in all prescribed camp activities, except as noted. I will make sure my child understands and agrees to abide by the restrictions noted on camp activities. I am aware that my child may be transported by bus or other vehicles authorized by Mound Ridge Camp and Retreat Center for approved trips out of camp/off-site activities. This completed form may be photocopied for trips out of camp/off-site.

I expect that my child will be well supervised during camp activities. I realize that individuals at camp can injure themselves at camp without fault on the part of Mound Ridge Camp and Retreat Center personnel. I release Mound Ridge Camp and Retreat Center from responsibility for injury to my child.

If my child is to take medication, I will instruct my child to take responsibility for taking dosages at scheduled times.

I hereby give permission to medical personnel selected by the Camp Director to order X-rays, routine test, treatments; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child (or me as staff/volunteer).

In case of emergency, I understand that every effort will be made to contact parents or guardians of the camper. In the event that I cannot be reached, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure treatment for my child as named herein. I hereby authorize the Camp Director and staff to act for me and on my behalf, according to their best judgement, in any emergency requiring medical attention to be administered to my child, until such time as I may be contacted. I give permission for the Mound Ridge Camp and Retreat Center designated staff member, to administer authorized medication and/or emergency treatment to my child during the camp/program session.

I understand that primary health and accident insurance protection are my responsibility.

I represent and agree that my child is in good health and physical condition and able fully participate in the entire camp program.

I have indicated any special health, medical or physical condition, including any required medication and activity limitations which should be known to camp staff, director, emergency medical personnel, doctors, physician assistances, or nurses

In signing this application, I hereby certify that I have read and understand the above statements and attest that the information that I have supplied on this form is correct to best of my knowledge.

Signature of Parent/Guardian _____

Parent/Guardian Name Printed _____ Date _____

Sworn to and subscribed before me this _____ day of _____, in the year _____

Notary Public: _____

Commission No. _____ My Commission Expires _____

Section V – Examination- to be completed by a licensed physician (Physical is good for 2 years)

This child has had a physical exam on the following date: ____/____/____ **Height**____ **Weight**____ **BP**____

1. Is the examination essentially normal? Please note any abnormal findings () Yes () No

2. Is there any mental, emotional, or physical condition for which the camper is under care? If yes explain () Yes () No

3. Is the camper on any routine medication? If yes, explain (name of medication, dosage, frequency) () Yes () No

4. Are there any defects or conditions which limit the camper's participation in any activities? If yes, please explain. () Yes () No

5. Has the camper had surgery of any kind, including Myringotomy (ear tubes)? If yes, please explain. () Yes () No

6. Known Allergies:

7. Dietary Restrictions:

8. Applicant is under the care of a physician for the following conditions:

9. Current treatment at the time of this report includes:

10. Dental Check Up () Yes () No

Print or type Physician's Name _____

Phone # _____ E-Mail _____

Required:

Signature of Licensed Physician/Physician Assistant _____ Date: _____