

# Skyview Ranch Camp Medical Form 2011

**Camper Information:** *Please bring this completed Medical Form to Camp Registration Day.*

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Gender:  M  F  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of Camp: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Weight: \_\_\_\_\_  
Week of Camp:  Day Camp  Junior  Pioneer Camp  Jr. High  Sr. High  Aviation Camp  Water Sports

**Parent/Guardian Information:**

Father/Guardian Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Mother/Guardian Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Alternate Emergency Contact Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Insurance Information:** *\*\*Please attach a copy of current Insurance Card to this Medical Form\*\**

Is the participant covered by family medical/hospital insurance?  Yes  No  
If yes, please indicate the insurance carrier or plan name: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Insurance Phone: \_\_\_\_\_ Insurance Address: \_\_\_\_\_  
Social Security Number of Primary Insurance Cardholder: \_\_\_\_\_ Cardholder Date of Birth: \_\_\_/\_\_\_/\_\_\_

**Family Doctor Information:**

Family Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

**Allergies:**

None  Medication Allergies  Food Allergies  Insect  Other Allergies

List all known allergies, describe **reaction** and **management** of the reaction.

**Medical Conditions:** List all known (asthma, diabetes, fainting, etc) and **treatments**.

Are there any reasons for restricting the camper's activities?  Yes  No

If yes, please explain: \_\_\_\_\_

**Medications:** *\*\*All medications must be in original container and are to be turned in at the time of check in\*\**

The following over-the-counter medications may be used as directed to manage common illnesses or injuries in the camp setting: Acetaminophen (Tylenol), Antacid (Tums), Diphenhydromine HCL (Benadryl), Ibuprofen (Motrin).

**Check One:**

It is OK to use these medications  Use these medications EXCEPT for: \_\_\_\_\_

Will this camper be on any prescribed and/or over-the-counter medications?  Yes  No

*If yes, please fill out the back of this form.*

**Immunization History:**

Immunizations are up to date:  Yes  No

If no, please contact the Ranch office for an Immunization Exemption Waiver at 330-674-7511 or online at skyviewranch.org.

Date of last Tetnus shot: \_\_\_\_\_

**Parent/Guardian Authorization for Health Care:**

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize and/or secure proper treatment for the person named above. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

**Signature of Parent/ Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Relation to Camper:** \_\_\_\_\_

**Health Officer Use only**

Date Screened: \_\_\_\_\_ Time: \_\_\_\_\_ Screened by: \_\_\_\_\_

Updates/additions to health history noted:  Yes  No  None Required

Meds Received:  Yes  No Current Health Needs identified:  Yes  No *If yes, please list below.*

Observational notes: \_\_\_\_\_

Camper's Name: \_\_\_\_\_

Date of Camp Week: \_\_\_\_\_

Week of Camp:

- Day Camp       Junior       Pioneer
- Jr. High       Sr. High       Aviation
- Water Sports

**Camper Medications Notes:**

- ✓ Medications MUST be in original packaging.
- ✓ The Camper's Name MUST be CLEARLY marked on each medication.
- ✓ Medications are given at Breakfast, Lunch, Supper, and Bedtime unless otherwise specified.
- ✓ Please do not mail this form ahead.
- ✓ For questions, please call: 330-674-7511

**Please list ALL medications being sent with camper (including over-the-counter medications).**

Name of Medication: \_\_\_\_\_

Time (s) Taken: \_\_\_\_\_

Dosage: \_\_\_\_\_

Reason: \_\_\_\_\_

Route:  By Mouth     By Drop     Other

Other Instructions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Health Officer Use Only						
Time	MON	TUES	WED	THUR	FRI	SAT

Name of Medication: \_\_\_\_\_

Time (s) Taken: \_\_\_\_\_

Dosage: \_\_\_\_\_

Reason: \_\_\_\_\_

Route:  By Mouth     By Drop     Other

Other Instructions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Health Officer Use Only						
Time	MON	TUES	WED	THUR	FRI	SAT

Name of Medication: \_\_\_\_\_

Time (s) Taken: \_\_\_\_\_

Dosage: \_\_\_\_\_

Reason: \_\_\_\_\_

Route:  By Mouth     By Drop     Other

Other Instructions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Health Officer Use Only						
Time	MON	TUES	WED	THUR	FRI	SAT

Name of Medication: \_\_\_\_\_

Time (s) Taken: \_\_\_\_\_

Dosage: \_\_\_\_\_

Reason: \_\_\_\_\_

Route:  By Mouth     By Drop     Other

Other Instructions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Health Officer Use Only						
Time	MON	TUES	WED	THUR	FRI	SAT

**Health Officer Use Only**

Health Officer Initial/ Signature \_\_\_\_\_  
Date \_\_\_\_\_

Medication returned to camper via counselor \_\_\_\_\_  
(initial)

Cabin: \_\_\_\_\_  
Page \_\_\_\_\_ of \_\_\_\_\_

Notes: \_\_\_\_\_

\_\_\_\_\_