Skyview Ranch Camp Medical Form

Please bring this completed Medical From to Camp Registration Day.

Camper Information:

Last Name:_____ First Name:_____ Gender: ❒ M ❒ F
Mailing Address: _____ City: _____ ST: _____ Zip:_____
Date of Camp: _____ Date of Birth: _____ Age: ____ Weight: ___
Camp Program: ❒ Day Camp ❒ Junior ❒ Pioneer Camp ❒ Jr. High ❒ Equine
❒ Sr. High ❒ Aviation ❒ Water Sports ❒ Worship

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
❒ Equine	❒ Jr. High	❒ Sr. High
❒ Aviation	❒ Water Sports	❒ Worship

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:________________

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Notes:____

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