2020 Summer Camp Health Form

TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN OF CAMPERS OR ANY STAFF MEMBER OVER 18 YEARS OF AGE

Camp Name/Date(s): **Capitol Youth Chorale Summer Camp July 6 – July 11, 2020**

The health form is kept confidential and used by our health services staff (or emergency medical personnel). **Every camper needs a completed health form to participate in the Capitol Youth Chorale summer camp program. Please fill out this form as completely as possible.** Thank you.

SECTION I – BASIC CONTACT INFORMATION

Camper
Name_____
LAST FIRST MIDDLE

Birth date_____/_____/_____ Age _____ Gender Male Female

Home
Address_____
STREET CITY STATE ZIP

Home Phone_____

Parent/Guardian #1
Name_____
Relationship: _____
Day Phone_____ Night Phone_____
Day Phone is **Home Work Cell** Night Phone is **Home Work Cell**

Parent/Guardian #2
Name_____
Relationship: _____
Day Phone_____ Night Phone_____
Day Phone is **Home Work Cell** Night Phone is **Home Work Cell**

Additional Emergency Contact_____ Relationship: _____
(In case we can't reach YOU)
Day Phone_____ Night Phone_____
Day Phone is **Home Work Cell** Night Phone is **Home Work Cell**

Family Physician Name_____ Phone_____

Dentist/Orthodontist Name_____ Phone_____

SECTION II – INSURANCE INFORMATION

Is the camper covered by family medical/hospital insurance? **Yes No**
If yes, indicate Insurance Carrier_____
Group #_____ Policy #_____
Policy Holder's Name_____ Relationship to participant_____

SECTION III – MEDICATIONS

Will camper be taking medications while at camp? **Yes No** *(Medications include prescription, over-the-counter, vitamins, inhalers, etc.)*

If camper will be taking medications while at camp, camp staff will distribute the medication to your camper as directed. The medication can be self-administered by the camper. Please list all (prescription and non-prescription). Include the medication name, prescribing physician, physicians' phone number, and the dosage instructions. Use an additional sheet if needed. When you check-in at camp, please provide all medications (in their original packaging that identifies the prescribing physician (if prescription drug), the name of the medication, the dosage, and frequency of administration.

_____ I want the medication or medical devices self-administered by my camper.
_____ A limited amount of medication for life threatening conditions should be carried by my son/daughter. (i.e. bee sting kits, inhalers)
_____ *Do we have your permission to administer Tylenol for minor discomforts? Yes ___ No ___*

Medication_____ Dosage_____ Take at what times_____
Reason for Taking_____
Prescribing Physician_____
Phone_____

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SECTION IV – ALLERGIES

Camper does not have any Allergies
Camper is allergic to
1. Hay Fever **2.** Poison Ivy/Oak **3.** Insect Stings **4.** Food **5.** Penicillin **6.** Other Drugs **7.** Other List allergy. Describe reaction and treatment
_____
_____
_____
_____.

SECTION V – IMMUNIZATIONS

Please record the month and year of immunizations. If you do not know the dates or whether camper has had certain immunizations, simply leave blank.

DPT (Diphtheria, Pertussis, Tetanus)..... _____
Tetanus Booster..... _____
Polio..... _____
MMR (Measles, Mumps, Rubella)..... _____
HIB (Haemophilus Influenza B)..... _____
Tuberculin Test ..... _____
Varicella (Chicken Pox)..... _____
Hepatitis B ..... _____

SECTION VI – HEALTH HISTORY

Please know that we value your privacy. Health History information is available only to the camp health staff. The more information you provide, the better we can do our job. Thanks!

Has the camper have a history of or is prone to any of the following (Please check all that apply).

__ 1.Recent injury, illness or infectious disease
__ 2. Chronic or recurring illness
__ 3. Asthma
__ 4. Homesickness
__5. Frequent Ear Infections
__ 6. Seizure Disorder or Convulsions
__ 7. Dizziness during or after exercise
__ 8. Chest pain during or after exercise
__ 9. Heart Defect/Disease
__ 10. Hypertension
__ 11. Bleeding/Clotting Disorders
__ 12. Diabetes
__ 13. Mononucleosis (in last 12 months)
__ 14. Chicken Pox
__ 15. Measles
__ 16. German Measles
__ 17. Mumps
__ 18. Tuberculosis
__ 19. Hepatitis
__ 20. Joint problems (knees, ankles)
__ 21. Fractures
__ 22. Frequent Headaches
__ 23. Head Injury
__ 24. Eating Disorder
__ 25. Diarrhea or constipation
__ 26. Frequent Stomachaches
__27.Wears glasses or contacts
__ 28. Been Hospitalized
__ 29. Wears a Medic Alert ID

Please list the number and provide explanation for any checked items

_____
_____
_____
_____
_____.

Date of Last Physical Exam (Recommended within 24 months of camp) _____

Physical Activities to be Limited or Restricted while at Camp

_____
_____
_____
_____.

SECTION VII – AUTHORIZATION

My child has permission to engage in all prescribed camp activities except as noted. The information provided on this form is accurate to the best of my knowledge. I have indicated any special health conditions, including required medication and activity limitations which should be known to the camp staff and medical personnel. I am aware of and accept the risk inherent in the program activity. I give consent in advance for medical treatment at an appropriate facility in case of illness or injury.

This form may be photocopied for use out of camp.

Signature of Parent or Guardian X_____
Date_____