



Camp Health Form

Please complete on form per camper

Please complete and mail this form to Camp Glen two (2) weeks prior to your camper's event.

A. Camper & Parent Information

Camper Name _____ Birth Date _____ Sex _____ Age _____
Last First Middle

Parent or Guardian _____ Phone _____

Home Address _____
Street & Number City State Zip

Cell Phone _____ Cell Phone _____ Email _____

Business Address _____
Street & Number City State Zip

Business Address _____
Street & Number City State Zip

If not available in an emergency notify:
 Name _____ Phone _____ Business Phone _____

B. Care Providers

Name of dentist/orthodontist _____ Phone _____

Name of family physician _____ Phone _____

Medical/hospital insurance carrier _____

Address _____ Phone _____

Policy # _____ Group # _____ I have no medical/hospital insurance.

Please attach a copy of your insurance card (both sides).

C. Medical Consent

Medical Consent Agreement

Participant's Name: _____

CERTIFICATION AND CONSENT TO AUTHORIZE MEDICAL CARE FOR MINOR. As the parent or legal guardian of the Participant whose name is set forth above, I hereby delegate to Camp Fire USA Northwest Ohio Council inc., Camp Glen, and their employees, clinicians, trainers, nurses, or agents, the authority to seek, obtain, and approve any medical care and treatment for the Participant including, but not limited to, x-ray examination, anesthetic, injection, medical, dental or surgical diagnosis, or treatment and medical care, which is deemed advisable by, and is to be rendered under the general supervision of any physician or surgeon, during, or as the result of, Participant's participation in the Activities. I authorize the release of any and all medical records concerning the Participant to any health care provider authorized to provide care or treatment pursuant to this Medical Consent Agreement. I authorize payment be rendered directly to hospital or doctor for benefits otherwise payable to me by any third party. I have read, and I understand, all of the provisions of this Agreement.

 Parent or Guardian's Signature Date Participant's Signature Date

 Parent or Guardian's Name (printed) Date Participant's Date of Birth

COMPLETE THE ENTIRE FORM

Please attach a copy of your insurance card (both sides)

Please complete this form and mail it to camp two weeks before the start date of your camp. If you are unable to mail the form, please bring it to camp. DO NOT mail the form to the Camp Fire USA Northwest Ohio Council office (in Findlay).

D. Allergies

The following information must be filled in by the parent/guardian. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant’s arrival in camp. Provide complete information so that the camp can be aware of your needs.

ALLERGIES List all known. Describe reaction and management of the reaction.

Medication allergies (list)

Food Allergies (list)

Other Allergies (list)

E. General Questions

(Explain “yes” answers below.)

	Yes/No		Yes/No
Has/does the participant:			
1. Have any recent injury, illness or infectious disease? .	Y / N	16. Ever been diagnosed with a heart murmur? ..	Y / N
2. Have a chronic or recurring illness/condition?	Y / N	17. Ever had back problems?	Y / N
3. Ever been hospitalized?	Y / N	18. Ever had problems with joints?	Y / N
4. Ever had surgery?	Y / N	19. Wear a removable orthodontic appliance? ...	Y / N
5. Have frequent headaches?	Y / N	20. Have any skin problems?	Y / N
6. Ever have a head injury?	Y / N	21. Have diabetes?	Y / N
7. Ever been knocked unconscious?	Y / N	22. Have asthma?	Y / N
8. Wear glasses, contacts, or protective eye wear?	Y / N	23. Had mononucleosis in the past 12 months? ..	Y / N
9. Ever had frequent ear infections?	Y / N	24. Had problems with diarrhea/constipation? ...	Y / N
10. Ever passed out during or after exercise?	Y / N	25. Have problems with sleepwalking?	Y / N
11. Ever been dizzy during or after exercise?	Y / N	26. If female, abnormal menstrual history?	Y / N
12. Ever had seizures?.....	Y / N	27. Have a history of bed-wetting?	Y / N
13. Ever had chest pain during or after exercise?	Y / N	28. Ever had an eating disorder?	Y / N
14. Ever had high blood pressure?	Y / N	29. Ever had emotional difficulties for which	
15. Ever had bleeding/clotting disorder?	Y / N	professional help was sought?	Y / N

Please explain “yes” answer(s), noting the number of the question(s).

Use this space to provide any additional information about the participant’s behavior and physical, emotional, or mental health about which the camp should be aware.

F. Restrictions

The following restrictions apply to this individual:

Dietary, circle all that apply

- Does not eat red meat Does not eat pork Does not eat eggs
- Does not eat poultry Does not eat seafood Does not eat dairy products

Other (describe) _____

Explain any restrictions to activity (e.g., what cannot be done, what adaptations or limitations are necessary).

G. Immunization History

Which of the following has the participant had?	Please give all dates of immunizations:					
	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
<input type="checkbox"/> Measles						
<input type="checkbox"/> German measles						
<input type="checkbox"/> Chicken pox						
<input type="checkbox"/> Mumps						
<input type="checkbox"/> Hepatitis A						
<input type="checkbox"/> Hepatitis B						
<input type="checkbox"/> Hepatitis C						
<input type="checkbox"/> TB Mantoux test						
Date of last test _____						
Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative						
	Tetanus					
	DTP					
	TD (tetanus/diphtheria)					
	Polio					
	MMR					
	or Measles					
	or Mumps					
	or Rubella					
	Haemophilus Influenza B					
	Hepatitis B					
	Varicella (Chicken pox)					

H. Medical Examination

To be filled out by a licensed Physician, Physician Assistant, or Registered Nurse. This examination should be performed within 24 months of arrival at camp. Examination for some other purpose within this period is acceptable. (Attach form.) Examination is for determining fitness to engage in strenuous activities. Please mark "S" for Satisfactory and explain any unsatisfactory items. (Attach page)

Height _____ Weight _____ B.P. _____

Eyes _____ Throat _____ Abdomen _____ General Appraisal: _____

Glasses/Contacts _____ Heart _____ Hernia _____ Ears _____ Skin _____

Extremities _____ Nose _____ Lungs _____ Posture (Spine) _____

Allergy (Please specify) _____

Recommendations and restrictions while in camp: Special Diet (See Section F) _____

Current Medications _____

Swimming _____ Strenuous activity _____

Other _____

(For Girls and Women) Has this person menstruated? _____ If not, has she been told about it? _____

If so, is her menstrual history normal? _____ Special considerations: _____

I have examined the person herein described and have reviewed the health history. It is my opinion that this camper is physically able to engage in camp activities, except as noted above.

Physician, Physician Assistant, or Registered Nurse

Date

Telephone _____ Address _____

Over The Counter Medications

(if you do not want your child treated with any of the following while at camp, cross it off and initial)

Camper Complaint

Minor aches & pains, headaches, toothaches or elevated temperature
Itching, rash, poison ivy, insect bites or sunburn
Mild diarrhea (w/o other symptoms)
Upset stomach
Minor cuts, scratches, abrasions
Mosquito, insect bites
Itchy, watery eyes, sneezing, runny nose
Stuffy nose
Sore throat
Sun exposure

Medicine Administered (May be generic equivalent)

Motrin or Tylenol
Benadryl, Calamine, Aveno, 1% Hydrocortisone Cream, Technu, Aloe
Immodium
Tums, Pepto Bismal
Triple antibiotic (Neosporin), Sterile Wipes
Insect repellent, Skeeter Stik, After Bite
Benadryl tablet
Sudafed
Throat lozenges
Sunscreen

MEDICATIONS BEING TAKEN Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. **Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. All medications, including over-the-counter/nonprescription, must be turned in to the Health Officer at registration.**

This person takes NO medications on a routine basis. This person takes medications as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #3 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Attach additional pages if needed.

Identify any medications taken during the school year that the participant does/may not take during the summer:

CONSENT TO USE VOICE AND IMAGE

We respect and want to protect the privacy of our campers and staff. We, therefore, thought you would like to know that at some point during your attendance at Camp Glen, we might ask to photograph, videotape, film and/or interview you. We might do this because we believe that our campers and staff offer two great reasons to attend Camp Glen, and we would like to be able to show you off by publishing in good taste some of the photographs, video, film and/or interviews for promotional purposes. To this end, the purpose of this document is to ask your permission in advance to capture your voice and image and possibly publish them in a Camp Glen medium. Accordingly, if you are willing to give us such permission, please read carefully and then execute this Consent to Use Voice and Image. If you are a camper or staff member age 18 or older, please sign the line over the designation "Signature of Adult Camper or Staff Member." If you are a camper or staff member under age 18, one of your parents or your legal guardian must give us permission on your behalf by signing the line over the designation "Signature of Parent or Guardian of Minor Camper or Staff Member." By signing below I acknowledge and agree to the following:

1. I give my permission to Camp Fire USA Northwest Ohio Council and Camp Glen including the owners, trustees, officers, employees, agents and volunteers of these entities, to photograph, videotape, film and/or interview me during my attendance at a Camp Glen event for the purpose of promoting or reporting on Camp Glen.

2. I, at any time, may decline to be photographed, videotaped, filmed and/or interviewed.

3. I give my permission to Camp Fire USA Northwest Ohio Council and Camp Glen, including the owners, trustees, officers, employees, agents and volunteers of these entities, to publish any such photographs, video, film and/or interviews for the purpose of promoting or reporting on Camp Glen. Further, I understand that publication may include, without limitation, use of any such photographs, video, film and/or interviews on Camp Glen websites, brochures and/or videos dealing with the Camp Glen events.

- Yes, I give permission for myself, (Adult Camper or Staff Member) or my child to be photographed
- ** No, I do not give permission for myself, (Adult Camper or Staff Member) or my child to be photographed

Signature of Parent or Guardian _____ Date _____
of Minor Camper or Staff Member

(IF CAMPER OR STAFF MEMBER IS UNDER AGE 18)

Signature of Adult Camper _____ Date _____
or Staff Member

(IF CAMPER OR STAFF MEMBER IS AGE 18 OR OLDER)

**By checking "no" you child's pictures WILL NOT be posted on Bunk1, our password-protected online photo gallery for parents.

Screening Record (For Camp Use Only)

Date screened _____ Time _____ pm

Meds received? Yes (if yes, see additional page) No

Current health needs identified _____

Notes _____

Screened by _____