Camp Celo

775 Hannah Branch Road

Burnsville, NC 28714

828-675-4323

Medical Form Package Instructions:

These forms are required of all campers. Please complete and return by May 1st.

1. Our medical forms are detailed; **if an applicable section is not completed, the forms will be returned to you for completion.**
2. Pages 1 and 2 are to be completed by the Parent/Guardian.
3. Page 3 is the physical exam that needs to be completed and signed by your camper's health care provider within **12 months** of camp attendance. The Parent/Guardian also needs to sign this form.
4. If your camper is not fully immunized you will have to sign the waiver on page 3.
5. Page 4 is the medication authorization form that your health care provider and parent/guardian both have to sign.
6. Page 5 is required by our local hospital in case of emergency. **This must be notarized.**
7. **Please make sure all pages of the health form packet are completed with all required signatures.**
8. **ATTACH A COPY OF INSURANCE CARD (front and back)**

Taking the time to complete these forms thoroughly ensures that we can provide excellent care for your camper. If you have any questions please email Annie Barrus, FNP at annie@campcelo.com.

Thank you for your help, we look forward to a healthy and safe summer!

CAMP CELO HEALTH FORM

CAMPER OR STAFF INFORMATION

(circle one) Junior/Session: A B C D E Senior/Session: 1 2 3 Staff/Sessions: 1 2 3

Last Name _____ First _____
Gender (circle one): M F Date of Birth_____ Age on arrival at Camp _____
Home Address _____
City _____ State _____ Zip_____
SS# _____

EMERGENCY NOTIFICATION

	Parent 1	Parent 2	Alternate Emergency Contact
Name			
Home #			
Work #			
Mobile #			
Email			

PHYSICIAN INFORMATION

	Name	Phone
(Primary) Health Care Provider		
Other:		
Dentist		

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

Camper/staff covered by family medical/hospital insurance? ___ Yes ___ No
Insurance Company _____ Policy Number _____
Subscriber _____ Insurance Company Phone Number _____
Do you have a prescription plan? ____ Yes ____ No Separate card? _____ Yes ____ No

ALLERGY INFORMATION

	Allergy	**Reaction**	**Action Plan?**
Medication			
Food			
Environment (hay fever, insects, etc.)			

DIET, NUTRITION

Indicate special food needs if camper does NOT eat regular diet:

RESTRICTIONS

Any restrictions to camper's activity? (e.g. what cannot be done; are adaptations or limitations required):

GENERAL HEALTH HISTORY FORM

(Parent/Guardian should complete. REQUIRES REVIEW BY Health Care Provider)

Has/does the camper: (If Yes explain in space provided).

1. Ever been hospitalized? Y or N _____
2. Ever had surgery? Y or N _____
3. Have recurrent or chronic illnesses? Y or N _____
4. Had a recent infectious disease? Y or N _____
5. Had a recent injury? Y or N _____
6. Had asthma/wheezing or shortness of breath? Y or N _____
7. Have diabetes? Y or N _____
8. Had seizures? Y or N _____
9. Had headaches? Y or N _____
10. Wear glasses, contacts or protective lenses? Y or N _____
11. Had fainting or dizziness? Y or N _____
12. Passed out or had chest pain during exercise? Y or N _____
13. Had mononucleosis ("mono") during the past 12 months? Y or N _____
14. If female, problems with menstruation? Y or N _____
15. Ever had back/joint problems? Y or N _____
16. Problems with falling asleep/sleepwalking? Y or N _____
17. History of bedwetting? Y or N _____
18. Problems with diarrhea or constipation? Y or N _____
19. Have any skin problems? Y or N _____
20. Traveled outside the country in last 9 months? Y or N _____

(Name countries visited and dates of travel in space below).

_____

_____

Mental, emotional and social health: Circle "Yes" or "No" for each statement.

Has the camper:

1. Ever been treated for Attention Deficit Disorder (ADD) or Attention Deficit/Hyperactivity Disorder (ADHD)? **Y or N**
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? **Y or N**
3. During past 12 months, seen a professional to address mental/emotional health concerns? **Y or N**
4. Had significant life event that continues to affect camper's life? **Y or N**

Please explain "yes" answers in the space below, noting number of question.

Additional Information: Please provide any additional information about camper's health that you think important or that may affect camper's ability to fully participate in the camp program.

HEALTH HISTORY & PHYSICAL EXAM FORM

(REQUIRES HEALTH CARE PROVIDER REVIEW & SIGNATURE)

Physical examination must be within 12 months of child's stay.

PLEASE HAVE HCP REVIEW CAMPER'S HEALTH HISTORY FORMS AT TIME OF EXAM.

Camper Name: _____ DOB: _____

Date of physical exam: _____

Height: _____ Weight: _____ Blood Pressure: _____
Allergies? Y or N Explain: _____
Special Diet? Y or N Explain: _____
Special Needs? Y or N Explain: _____
May participate in all camp activities? Y or N Explain: _____
May participate except for: _____

General Appraisal: _____
_____
_____
_____

If camper is undergoing treatment for any acute or chronic condition, describe: _____
_____
_____
_____

Immunizations up to date? Y or N Date of last Tetanus shot? _____

FOR PARENT/GUARDIAN**: If your camper has not been fully immunized, please sign the following statement. I understand and accept the risks to my child from not being fully immunized.**

Signature of parent/guardian: _____ Date: _____

For HCP**: I have reviewed the HEALTH HISTORY FORMS and have discussed the camp program with camper's parent(s)/legal guardian. I have examined this child and find him/her to be physically and emotionally fit to participate in an active camp program (except as noted above).**

Name of licensed provider (please print): _____ Title: _____

Office address _____ Phone number _____

Signature of HCP _____ Date: _____

HEALTH HISTORY FORM

(REQUIRES HEALTH CARE PROVIDER REVIEW & SIGNATURE)

MEDICATION AUTHORIZATION

The following OTC (over the counter) medications may be available in Camp first aid boxes and are used on an as needed basis to manage illness and injury. Cross out those your camper should NOT be given.

Acetaminophen (pain, fever)
Allergy medicine (diphenhydramine, loratadine)
Ibuprofen (pain, fever, anti-inflammatory)
Loperamide (diarrhea)
Phenylephrine decongestant (Sudafed PE)
Dextromethorphan cough syrup (Robitussin DM)
Guaifenesin cough syrup (Robitussin)
Generic cough drop
Antibiotic cream
Calamine lotion (topical for skin irritation)
Tums (indigestion, diarrhea)
Milk of Magnesia (constipation)
Bismuth subsalicylate/Pepto Bismol (diarrhea)
Lubricant eye drops
Eye allergy eye drops
Anti-fungal cream
Zinc lozenges
Sting Stop
Rhus Tox (homeopathic for poison ivy, inflammation)
Ivy Rest (homeopathic cream for poison ivy)
Arnica (homeopathic cream or pellets for muscle strain/injury)
Hydrocortisone cream (topical for skin irritation)
Rescue Remedy (homoeopathic anti-stress remedy)
Nux vomica (homeopathic for nausea)

CURRENT MEDICATIONS: "Medication" is any substance a person is taking to maintain and/or improve health. This includes vitamins & natural remedies. If camper or staff is taking any medications please indicate below. Medications must arrive at camp in **original pharmacy containers with labels which show camper's name and how medication should be given.** Please provide enough of each medication to last entire camp session.

Name of Medication	Dosage	Route	Schedule	Reason for Taking

Date of Standing Orders for Medication Administration: _____
Signature of Physician/Health Care Provider _____
Printed Name _____ Phone Number _____

Parent/Guardian Authorization
I hereby give permission for the camp staff to administer the above prescribed medications and/or non-prescribed (generic equivalents may be used) to my child:
Parent or Guardian Name (print) _____
Parent or Guardian Signature: _____ Date: _____

MEDICAL AUTHORIZATION FORM

MEDICAL PERMISSION STATEMENT & DISCLOSURE OF MEDICAL INFORMATION

I, the undersigned parent or legal guardian of _____, a minor child, am willing and desire that my child (or ward) attend Camp Celo and that I assume any risks normally inherent in the nature of the Camp Celo program. I hereby give permission to the camp to provide routine health care, administer standing orders, seek emergency medical treatment including x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. Furthermore, in the event I cannot be reached in an emergency I do hereby authorize Camp Celo to seek and consent to all necessary medical treatment for the aforementioned child by the appropriate medical personnel.

This the _____ day of _____ 20_____.

_____ signature

_____ (State)
_____ (County)

I, _____ a Notary Public for said County and State, do hereby certify that

_____ (and _____) personally appeared before me this day and acknowledged the due execution of the forgoing instrument.

Witness my hand and official seal, this _____ day of _____ 20_____.

(Official Seal)

_____ Notary Public

My commission expires: _____