

Koinonia Conference Grounds 2010 Camper Health Form

PLEASE SUBMIT A COPY OF YOUR CHILD'S IMMUNIZATION RECORDS WITH THIS FORM.

Full Name: _____ Date of Birth: _____ Age at Camp: _____
Home Address: _____ Gender: Male Female
City: _____ State: _____ Zip Code: _____
Camper Lives With (name): _____ Relationship to Camper: _____

Camp Week – (check all that apply): Water Sports Kids 1 Jr High Kids 2

The information provided on this form will be used to brief kitchen staff about nutritional needs, educate Cabin Leaders & the Camp Director about camper needs, and provide Healthcare Staff with background about your child. Receiving adequate information at least two weeks prior to your child's arrival is crucial to our ability to provide the proper supportive environment. Please read and complete this form thoroughly.

HEALTH HISTORY: To be completed and signed by parent or guardian. Please keep a copy for your records and to record changes in your child's health status. Please notify Koinonia Conference Grounds in writing if there are any changes.

ALLERGIES: Please mark those that apply to this camper.

This camper has no known allergies.

This camper has an allergy to the following: (List all foods, medications, and substances) _____

_____ *Does this cause anaphylaxis?* Yes No Unknown

Please describe allergic reaction (if any) and what steps are taken to manage it (attach additional information if needed): _____

NUTRITION: We are able to work with some medically prescribed diets but are unable to cater to individual food preferences. Please mark those that apply to this camper. Please call if you have any questions.

This camper eats a regular, varied diet

This camper is lactose-intolerant. (*Our expectation is that the camper will bring his/her own supply of products (such as Lactaid) and will contact the nurse or health coordinator when the supplement is needed.*)

CHRONIC CONCERNS: Please mark all that pertain to this camper and provide information about supportive health care.

This camper has no chronic health concerns and is capable of full participation in this program.

This camper has the following chronic health concern(s):

Asthma

Headaches

Sleepwalking

Diabetes

Hearing Difficulties

Menstrual Cramps

Frequent ear infections

Bedwetting

Bee Sting Allergy

Seizure Disorder

Surgical History

Fainting

Fears/Phobias

Other (please describe): _____

Please provide information about supportive health care needed for each marked item (if any): _____

If *Surgical History* is marked above, please explain: Date of Surgery: _____ Type of surgery: _____

Are all symptoms resolved? Yes No - Please explain: _____

Is the camper cleared by parent and physician for active camp participation? Yes No Date of last Tetanus shot: _____

Camper's Physician: _____ Office Phone: (____) _____

Camper's Dentist: _____ Office Phone: (____) _____

MEDICATIONS: All medications MUST be in original, pharmacy-provided containers and appropriately labeled. Please attach a note if the camper has been taking current dose for less than three months prior to arrival or if there are any changes.

This camper does not take any medication.

This camper takes daily medication:

1. Medication: _____ Reason for Taking: _____

Dose Taken: _____ How often each day? _____

2. Medication: _____ Reason for Taking: _____

Dose Taken: _____ How often each day? _____

3. Medication: _____ Reason for Taking: _____

Dose Taken: _____ How often each day? _____

MEDICATIONS (continued):

The following medications, stocked in the Gauze Pad/Health Center, are used to manage illness or injury and dispensed as directed by our medical protocols. Generic form may be used. Please cross-out any medicine your camper **should not** be given:

Acetaminophen (Tylenol)	Aloe	Antacid	Bismuth Chewable Tablets
Calamine Lotion	Chamomile Tea	Cough Drops	Diphenhydramine (Benadryl)
Dramamine	Guaifenesin DM (Cough Med)	Hydrocortisone Cream	Ibuprofen (Motrin)
Insect Repellent	Iodine Swabs	Kaopectate/Anti-Diarrheals	Nix
Pepto Bismol	Pseudoephedrine	Tinactin	Triple Antibiotic Cream

MENTAL, EMOTIONAL AND SOCIAL HEALTH: Please mark YES or NO for each statement.

1. This camper has been diagnosed with ADD or ADHD Yes No
2. This camper has psychiatric diagnosis such as depression, OCD, panic/anxiety disorder Yes No
3. This camper has an emotional health concern Yes No
4. During the past academic year, this camper has seen or is currently seeing a professional to address mental/emotional health concerns. Yes No
If yes, please specify: _____
5. This camper has had a significant life event that continues to affect the camper's life Yes No
If yes, please provide written information about the event.

WHAT HAVE WE FORGOTTEN TO ASK? Please provide additional information about your child's health which may have been neglected on this form. We are particularly interested in information which has impact upon your child's ability to fully participate in our active camp program.

BILLING INFORMATION FOR HEALTH CARE: Parents/Guardians are financially responsible for health care given by an out of camp provider. To whom should this provider route charges for your campers health care if the need arises? Please include a copy of an insurance card if appropriate. Please copy both sides of the card so addresses and telephone numbers are readable.

This camper is not covered under an insurance policy.

This camper is covered under the following health insurance:

Insurance Company: _____ Policy/Member #: _____

Insurance Company Telephone: (_____) _____ Name of Subscriber: _____

Insurance Company Address: _____ City: _____ State: _____ Zip: _____

PARENT CONTACT INFORMATION: We will call in the event of an emergency or if we have questions about your child. Please provide contact information for other people who know your child and with whom we can consult if we cannot reach you. We will assume you have spoken with these individuals and that they are willing to assist, should the need arise.

Custodial Parent/Guardian: _____ Daytime Telephone: (_____) _____

Address: _____ Evening Telephone: (_____) _____

City: _____ State: _____ Zip: _____ Cell Phone: (_____) _____

Alternate Contact: _____ Telephone: (_____) _____

Relationship to Camper: _____

Alternate Contact: _____ Telephone: (_____) _____

Relationship to Camper: _____

PARENT/GUARDIAN CONSENT AND AUTHORIZATION FOR HEALTH CARE: This health history is correct and the camper described has permission to participate in all activities, which may include the high ropes course, surfing, or mountain biking, except as noted by me and/or the examining physician. I will not hold Koinonia Conference Grounds or its agents liable for injury caused by common accident, illness, or the rendering of emergency care. I give permission for this child to participate in any offsite activities during camp and to be transported to and from any offsite activities, including emergency situations (if any) by authorized vehicles. Koinonia Conference Grounds has my permission to obtain a copy of my child's health record from the providers who treat my child. I understand that information about my child's health will be shared on a "need to know" basis with other Koinonia Conference Grounds staff. I give permission to the physician selected by Koinonia Conference Grounds to order X-rays, routine tests and treatment for the health of my child. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for my child. This form may be photocopied. By signing below, I give permission to Koinonia Conference Grounds to use video or photography of me or my family members for promotional purposes.

***SIGNATURE OF CUSTODIAL PARENT/GUARDIAN:** _____ **DATE:** _____