



# ECHO LAKE CAMP 2017

## HEALTH HISTORY/MEDICAL AUTHORIZATION

Program: \_\_\_\_\_  
Session # \_\_\_\_\_

**Important: Please review this form prior to your child arriving at camp. Parent(s) is responsible for notifying staff of any updates to the medical authorization form, at least 2 weeks in advance of camp attendant.**

CAMPER INFORMATION			
FULL NAME:	AGE	GENDER	
LEGAL PARENT / GUARDIAN			
FULL NAME:	RELATIONSHIP TO CAMPER	PHONE:	CELL:
EMERGENCY CONTACT PERSON			
FULL NAME:	RELATIONSHIP TO CAMPER	PHONE:	CELL:
MEDICAL CONTACT			
FAMILY PHYSICIAN:	PHONE:	INSURANCE CARRIER	POLICY NUMBER
MEDICAL INFORMATION			
Allergies (list all known) including allergies to medication. Allergy: _____			
Describe reaction and management of the reaction: _____			
<b>Medical History</b> (Check if your child has had any of the following):			
<input type="checkbox"/> Measles	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> German Measles	<input type="checkbox"/> Mumps
		<input type="checkbox"/> Hepatitis	
Should the camp make any special medical preparations/accommodations for your child? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please explain: _____			
<b>Has child ever been limited in physical activity for any reason?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please explain: _____			
Please list any other pertinent health information that would be helpful to us. (Consider the altitude of the mountain environment, hiking, mosquitoes, etc.): _____			

## MEDICATIONS

Please list ALL Medications (including over-the-counter or nonprescription drugs) taken routinely and/or within the past 90 days.

If your camper requires medication be administered at Camp, pack enough medication to last the entire stay. Keep medication in the original packaging that identifies the prescribing physician (if a prescription drug), name of the medication, the dosage, and frequency of administration.

This person takes NO medications

This person takes medication as follows:

Med #1	Dosage	Specific time(s) each day
Reason for taking		Name / PH# of prescribing physician
Med #2	Dosage	Specific time(s) each day
Reason for taking		Name / PH# of prescribing physician
Med #3	Dosage	Specific time(s) each day
Reason for taking		Name / PH# of prescribing physician

## GENERAL QUESTIONS (EXPLAIN "YES" ANSWERS BELOW)

My child's health history includes::

	YES	NO		YES	NO
1. Recent injury, illness or infectious disease	<input type="checkbox"/>	<input type="checkbox"/>	16. Back problems	<input type="checkbox"/>	<input type="checkbox"/>
2. Chronic or recurring illness/condition	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (knees, ankles)	<input type="checkbox"/>	<input type="checkbox"/>
3. Hospitalized in past year	<input type="checkbox"/>	<input type="checkbox"/>	20. Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
4. Surgery impacting daily activity	<input type="checkbox"/>	<input type="checkbox"/>	21. Asthma	<input type="checkbox"/>	<input type="checkbox"/>
5. Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>	22. Mononucleosis in the past 12 months	<input type="checkbox"/>	<input type="checkbox"/>
6. Head injury	<input type="checkbox"/>	<input type="checkbox"/>	23. Problems with diarrhea/constipation	<input type="checkbox"/>	<input type="checkbox"/>
7. Knocked unconscious	<input type="checkbox"/>	<input type="checkbox"/>	24. Problems with sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eyewear	<input type="checkbox"/>	<input type="checkbox"/>	25. Abnormal menstrual history	<input type="checkbox"/>	<input type="checkbox"/>
9. Frequent ear infections	<input type="checkbox"/>	<input type="checkbox"/>	26. History of bed-wetting	<input type="checkbox"/>	<input type="checkbox"/>
10. Fainted during or after exercise	<input type="checkbox"/>	<input type="checkbox"/>	27. Emotional difficulties for which professional help was sought	<input type="checkbox"/>	<input type="checkbox"/>
11. Dizzy during or after exercise	<input type="checkbox"/>	<input type="checkbox"/>	28. Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>
12. Seizures	<input type="checkbox"/>	<input type="checkbox"/>	29. ADD or ADHD	<input type="checkbox"/>	<input type="checkbox"/>
13. Chest pain during or after exercise	<input type="checkbox"/>	<input type="checkbox"/>	Please explain any "yes" answers, noting the number of the questions:		
14. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____		
15. Diagnosed with a heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____		

## PARENTAL CONSENT AND AUTHORIZATION FOR MEDICAL TREATMENT

This health history is correct to the best of my knowledge and the person herein described is in good health and has my permission to engage in all prescribed camp activities, including but not limited to, swimming, rafting, canoeing, and hiking while at Camp except as noted. I have completed and understand the above Health History information and Medical Authorization form(s). Authorization for treatment: In the event that I cannot be reached, I hereby give permission to the medical personnel selected by COB Camps to order, secure, and/or administer, as necessary, medical tests, treatment, transportation and hospitalization for my child as named above.

It is permissible for the Camp Medical Staff to administer the following over-the-counter drugs to my child, if needed (Check all that apply):

- Tylenol   
  Advil   
  Neosporin (Triple Antibiotic Ointment)   
  Sunscreen   
  Tums (Calcium Carbonate)
- Bug Spray   
  Benadryl (Oral / Topical)   
  Pepto-Bismol   
  Hydrocortizone (Anti-Itch Cream)

Parent/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_