Recreation Division

ECHO LAKE CAMP 2019

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: _____

_____

_____

Medical History (Check if your child has had any of the following):

☐ **Measles** ☐ **Chicken Pox** ☐ **German Measles** ☐ **Mumps** ☐ **Hepatitis**

Should the camp make any special medical preparations/accommodations for your child? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Has child ever been limited in physical activity for any reason? ☐ **Yes** ☐ **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
1. Recent injury, illness or infectious disease	❑	❑
2. Chronic or recurring illness/condition	❑	❑
3. Hospitalized in past year	❑	❑
4. Surgery impacting daily activity	❑	❑
5. Frequent headaches	❑	❑
6. Head injury	❑	❑
7. Knocked unconscious	❑	❑
8. Wear glasses, contacts or protective eyewear	❑	❑
9. Frequent ear infections	❑	❑
10. Fainted during or after exercise	❑	❑
11. Dizzy during or after exercise	❑	❑
12. Seizures	❑	❑
13. Chest pain during or after exercise	❑	❑
14. High blood pressure	❑	❑
15. Diagnosed with a heart murmur	❑	❑
16. Back problems	❑	❑
17. Ever had problems with joints (knees, ankles)	❑	❑
20. Diabetes?	❑	❑
21. Asthma	❑	❑
22. Mononucleosis in the past 12 months	❑	❑
23. Problems with diarrhea/constipation	❑	❑
24. Problems with sleepwalking	❑	❑
25. Abnormal menstrual history	❑	❑
26. History of bed-wetting	❑	❑
27. Emotional difficulties for which professional help was sought	❑	❑
28. Eating disorder	❑	❑
29. ADD or ADHD	❑	❑

Please explain any "yes" answers, noting the number of the questions:

_____

_____

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: _____