Youth Medical Form

Camper's Last Name_____ First Name _____ Middle Name _____

Camper's Address_____City_____State_____Zip_____

Age_____ Date of birth _____ Gender (circle one): M / F / Non-binary

Youth Event (circle one): Junior / Chi Rho / CYF I / CYF II / Feb Camp / Fall Fest

The following information is required to ensure that your child's individual needs are met while attending camp. Information is confidential and will be made available only to those people who are directly responsible for your child's wellbeing. In the event of an emergency, every effort will be made to contact the parent/guardian. No person will be allowed to attend camp without a completed and signed copy of this form.

MEDICAL HISTORY: Has your child been subject to any of the following? Please check all that apply.

	In past year	More than 1 year ago		In past year	More than 1 year ago
Diabetes			Hyperactivity		
Epilepsy			Convulsions		
Heart disease			Fainting spells		
Rheumatic fever			Tires easily		
Chicken pox			Nosebleeds		
Rubella			Eye/ear problems		
Mumps			Fractures		
Whooping cough			Muscle sprains		
Scarlet fever			Bed wetting		
Hepatitis			Depression		
Encephalitis			Other (specify)		
Emotional problems					

Does your child have any allergies? _____

Are immunizations up to date? _____ Date of last tetanus booster: _____ Date of last DPT booster: _____

Usual source of care: Physician _____ Phone no. _____

Dentist_____ Phone no. _____

Eye Doctor _____ Phone no. _____

Glasses? _____ Contact Lenses? _____ ___

Health Insurance Carrier and no.: _____

Is your child currently under care of a physician?_____ Counselor?_____ If yes, please give additional information: _____

_____

_____

Does your child have any special dietary needs? (Please specify food allergies, if vegetarian, etc.) _____

_____

Is there additional information, which would be of help in promoting your child's welfare while at Feb camp? _____

_____

_____

Are there activities your child should not participate in while at camp? ☐ Yes ☐ No If so, please explain _____

_____

As-needed Medications

If you **do not** wish to have your child treated using the following medications in the event of the presence of the symptoms indicated, please check the "No" column. If the treatment listed below is acceptable for the corresponding symptoms, **do not send the listed medication.** These non-prescription drugs will be provided. (Generic brands may be substituted for name brands listed here.)

Symptoms	Treatment	NO	Symptoms	Treatment	NO
Upper Abdominal Pain	Liquid Maalox		Fever, Flu; Headache	Ibuprofen, Acetaminophen	
Nausea	Maalox		Menstrual Cramps	Ibuprofen, Acetaminophen	
Allergy, Hives, Bites	Chlortrimatron, Benadryl		Muscle Spasm	Ibuprofen	
Acute respiratory reaction to insect bites	Adrenaline		Poison	Ipecac or Charcoal **Doctor will be called first**	
Constipation	Milk of Magnesia		Rash	Cortaid Cream	
Cough	Robitussin DM		Sinusitis	Sinutab	
Cuts	Hibaclens and Polysporin		Sore Throat	Throat Lozenge, Acetaminophen	
Diarrhea	Imodium AD		Sunburn	Solarcaine (**if not allergic to –caines)** & Ibuprofen	
Earache	Auralgan **(if not allergic to –caines)**, Sinutab, Afrin		Vomiting	Pedialite	
Eye Irritation	Visine AC				

Medications: Please list amount and times for each medication that your child takes on a regular basis. This information can be updated at any time or when your child arrives at camp. All medications must be in their original packaging and will be administered by the health supervisor during camp. All medicines, including vitamins, must be turned over to the camp health care supervisor.

Medication	Dosage	Interval	Purpose

Medical Release Statement (MUST be signed)

My Child _____ **is in good health.** I will notify the camp director if my child is exposed to any communicable disease during the two weeks prior to attending camp.

In case of medical emergency, I give my permission to the physician selected by the Camp Director, Camp Health Care Provider, or other authorized camp staff member to secure proper treatment for, hospitalize and order injection, anesthesia or surgery for my child

Parent/Guardian Signature_____ Printed Name_____ Date_____
Insurance Provider _____ Group name or number _____ ID number _____

Phone Numbers: _____ _____ _____
Home Office Cellular