

LIONS WILDERNESS CAMP

Camper CIT

Health History and Examination Form - **Required each year and must be submitted at least 3 weeks prior to camp.**

This side to be filled in by Parents / Guardians for minor age applicants

Please PRINT or TYPE. It is very important that we are able to read this information.

Last name: _____ First name: _____ Middle initial: ____

Birthdate: _____ Age at camp: _____ M F

Primary emergency contact: _____ Phone #: (____) _____

Primary contact email: _____ Secondary phone or email: _____

Name of Physician: _____ Phone #: (____) _____

Name of Dentist: _____ Phone #: (____) _____

Health Insurance Carrier: _____ Policy #: _____

--Include copy of front and back sides of medical insurance carrier cards--

We have no Health Insurance.

IMPORTANT - THE FOLLOWING MUST BE COMPLETED FOR ATTENDANCE

To the best of my knowledge, this health history is correct and the person herein described has my permission to engage in all camp activities except as noted. Furthermore he / she has no history of mental illness or behavioral issues that would compromise a positive camp experience.

Authorization for Treatment: I hereby give permission to the medical personnel selected by the Camp Director to order x-rays, routine tests, treatment, and necessary transportation for my child. In the event I cannot be contacted in an emergency, I hereby give permission to the physician selected by the Camp Director or designated medical personnel to secure and administer treatment, including hospitalization, for my child as named above. Campers' vaccination record containing inoculation dates will be presented upon arrival at camp. Completed medical forms may be photocopied for trips out of camp.

I hereby give permission for the camp medical staff to dispense OTC (over-the-counter) medication as needed to my child as checked below. Dosages will be administered according to directions on the container unless a physician directs otherwise.

- | | | | | |
|---------------------------------------|-----------------------------------|---|---|---|
| <input type="radio"/> Acetaminophen | <input type="radio"/> Aspirin | <input type="radio"/> Ibuprofen / Advil | <input type="radio"/> Pepto Bismol | <input type="radio"/> Midol |
| <input type="radio"/> Calamine lotion | <input type="radio"/> Benadryl | <input type="radio"/> Imodium AD | <input type="radio"/> Cough drops / syrup | <input type="radio"/> Stool softener / Laxative |
| <input type="radio"/> Tums | <input type="radio"/> Other _____ | <input type="radio"/> Other _____ | | |

Signature of Parent / Guardian _____ Date: _____

I understand and agree to abide with any restrictions placed upon my camp activities as noted on this form and agree to take prescribed medications as indicated.

Signature of Camper: _____ Date: _____

Note: Because medication cannot be secured in cabins, we consider all medications as dangerous to campers. Therefore, we require all prescribed and OTC medications be left with the nurse. All medications must be in original containers with instructions for administration in English. The medications will be available and administered anytime they are needed. Unused medications shall be returned at camp checkout.

PLEASE BE SURE THAT YOUR PHYSICIAN COMPLETES PAGE 2 and FORM IS SUBMITTED PRIOR TO CAMP.

Medical Exam and Evaluation -- to be filled out by medical personnel only

Name of Applicant _____ Date examined _____ Height _____ Weight _____

Please record the specific date (month / year) of the basic immunization and the most recent booster doses for TETANUS.

Vaccine	Date of basic immunization	Date of last booster
Tetanus (DPT / TD / T)		

Conditions: (Check all that apply and indicate continuous or date of last occurrence)

- | | | |
|---|--|---|
| <input type="checkbox"/> ADD / ADHD _____ | <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Back Injuries / problems _____ |
| <input type="checkbox"/> Bed Wetting _____ | <input type="checkbox"/> Bleeding Disorder _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Ear Infections _____ | <input type="checkbox"/> Head Injury _____ | <input type="checkbox"/> Heart Disease _____ |
| <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Migraines _____ |
| <input type="checkbox"/> Mononucleosis _____ | <input type="checkbox"/> Rheumatic Fever _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> ODD _____ | <input type="checkbox"/> Sore throat _____ | <input type="checkbox"/> Tuberculosis _____ |
| <input type="checkbox"/> Urinary Tract Infections _____ | <input type="checkbox"/> Psychiatric counseling/hosp _____ | <input type="checkbox"/> Autism _____ |

Please explain any checked items above or conditions not listed _____

Has this applicant had any serious injury, illness or surgery during this last year? ____ If Yes, explain: _____

Allergies (Check all that apply)

- | | | | | |
|---------------------------------------|---------------------------------------|--|--|----------------------------------|
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Iodine | <input type="checkbox"/> Drug allergies (list below) | <input type="checkbox"/> Food allergies (list below) | <input type="checkbox"/> stings* |
| <input type="checkbox"/> Insect Bites | <input type="checkbox"/> Other: _____ | | | |

If immediate medical attention is required for any allergy, specify treatment: _____

*If epinephrine is required, please give to camp nurse. Epinephrine MUST have a physician order on file to give.

Does the applicant require a special diet? ____ If yes, please explain: _____

Medications: Please list all medications to be continued while at camp.

Prescription Medication	Dosage	Specific Times taken	Reason

Over the Counter Medication	Dosage	Specific Times taken	Reason

Individual requires no regular medication.

Is there any medical reason why the applicant should not hike? (Hiking is an integral part of the camp program, as the camp elevation may range up to 300 ft. from the highest to lowest area.): _____

HEALTH CARE RECOMMENDATION BY LICENSED PHYSICIAN (REQUIRED)

I have examined the above applicant within the past two (2) years. This applicant appears in good physical condition and able to participate in an active camp program at an approximate altitude of 6,000 ft. I have no reason to restrict participation in any camp activities except as listed: _____

Physician's Name: _____ Signature: _____

Address: _____ Date: _____

City: _____ State: _____ Zip: _____

Day Phone: (_____) _____ Evening phone: (_____) _____

Date this form was completed: _____ By: _____