CAMPER MEDICAL & CONTROLLED RISK FORM

ALL SPACES MUST BE FILLED IN FOR THIS FORM TO BE ACCEPTED!

Camper Name: _____ ☐ Male ☐ Female

Camper Mailing Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Birth Date: _____ Age: _____

☐ Group Home ☐ IRSS (individual) ☐ SLS (Supported Living Services) ☐ Family

Name: _____ 24-Hr. Phone: _____

Relationship to Camper: _____

Camp Dates You Will Be Attending: ☐ CAMP HOPE 1: JUNE 15-19 ☐ CAMP HOPE 2: JUNE 22-26

Health History		
Check	Give Approximate Dates	
		Frequent Ear Aches
		Heart Defect/Disease
		Diabetes
		Bleeding/Clotting Disorders
		Hypertension
		Mononucleosis
		Chicken Pox
		Measles
		German Measles
		Mumps
		Hay Fever
		Poison Ivy/Oak
		Insect Stings
		Penicillin
		Other Drugs
		Asthma
		Other (specify)

Physician Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Operations or Serious Injuries: _____

Chronic or recurring illness/medical condition: _____

Dietary Restrictions: _____

Other Diseases: _____

Suggestions on health-related information for Camp Staff: _____

Do you carry Family Medical/Hospital Insurance? ☐ Y ☐ N

Company: _____

Policy or Group #: _____

CURRENT MEDICATIONS: PLEASE ATTACH ALL INFORMATION AND SEND WITH INSTRUCTIONS

IMMUNIZATION HISTORY

Required immunizations must be determined locally. Please record the date (month AND year) of basic immunizations and most recent booster. A current tetanus booster is needed to attend.

Vaccines	Year of Basic Immunization	Year of Last Booster

CAMPER MEDICAL & CONTROLLED RISK FORM *continued*

THIS FORM MUST BE FILLED OUT AND SIGNED BY A PHYSICIAN.

HEALTH CARE RECOMMENDATIONS BY LICENSED PHYSICIAN TO BE ADMINISTERED AT CAMP

All medications must be in original prescription bottle clearly marked as to content, dosage, and frequency .
If needed, attach additional pages to this form.

Any prescribed meal plan or dietary restrictions: _____

_____

_____

Any allergies (food, drugs, plants, insects, etc.): _____

_____

_____

Activities to be encouraged or limited: _____

_____

_____

Additional health information: _____

_____

_____

I have examined the above camp applicant within the last year. DATE EXAMINED: _____

In my opinion, the above condition(s) do(es) not preclude his/her participation in an active camp program.
RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP - Any treatment to be continued at camp:

_____

_____

_____

THE FOLLOWING BOX AND INFORMATION MUST BE FILLED OUT BY A LICENSED PHYSICIAN.

Licensed Physician's Signature: _____

Address: _____

Date of Form Completion: _____ **Phone:** _____

CAMPER MEDICAL & CONTROLLED RISK FORM *continued*

BUCKHORN CAMP CONTROLLED RISK ACTIVITY

This health history packet is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted.

AUTHORIZATION FOR TREATMENT:
I hereby give permission to the medical personnel selected by the Camp Director to order x-rays, routine tests, treatment to release any record necessary for insurance purposes; and to provide or arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Director to secure and administer treatment, including hospitalization, for the person named. The completed forms may be photocopied for trips out of camp. I understand and agree to abide with the restriction(s) placed on my camp activities.

_____ _____

Signature Date

RELEASE FROM LIABILITY:

I give permission for _____ to participate in horseback riding, boating, and challenge course activities while at Buckhorn Camp/Camp Hope. I understand that these are activities that involve a degree of risk and that only qualified leadership will be used. I understand that by signing this waiver I am releasing Buckhorn Camp/Camp Hope Staff from all liabilities in the event of an injury or Accident.

I also give my permission for any necessary medical/surgical treatment that may be necessary in the unlikely event that an accident should occur.

_____ _____

Signature of Parent or Legal Guardian Date