CAMP FIRE USA CAMP WILANI DAY CAMP HEALTH FORM 2010

Camp Fire USA

Name ____________________________________ **Birth Date** _____________ **Gender: M** ____ **F** _____

Parent/Guardian ____

Phone (Hm) ________________________ (Wk) _________________________ (Cell)________________________

2nd Parent/Guardian ____

Phone (Hm) ________________________ (Wk) _________________________ (Cell)________________________

Additional Parent Information: Name(s) ____

Contact #s ____

Insurance Information

Is the participant covered by family medical/hospital insurance? Yes ___ No ___ SSI# or ID#________________________

Indicate carrier/plan name ____

Group # ____

Carrier address ____

Name of Insured ____Relationship to participant ___________________

Health History

Please attach a note with any other information that will help us serve your child.

The following information must be filled in by the parent/guardian. The intent is to provide camp health care personnel with background needed to provide appropriate care.

☐ ADD ☐ ADHD ☐ Asthma-Mild ☐ Asthma Severe ☐ Visual Impairment ☐ Blind ☐ Diabetes ☐ Hearing Impaired ☐ Deaf
☐ Epilepsy or Seizures ☐ Hyperactive ☐ Autism Spectrum Disorder ☐ Speech/Language Impairment

ALLERGIES (list all known)

Medication, Food, Other ____
____

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Send in original packaging, with RX label.

Med # 1 ____________________________ Dosage __________________ Reason____

Med # 2 ____________________________ Dosage __________________ Reason ____

IMMUNIZATIONS

Are all participants' immunizations current? Yes ____ No ____ If not give reason ____
Date of last DtaP/DTP/DT/Td: Year _____________ MMR Current? Yes ____ No ____

ADDITIONAL INFORMATION about participant's emotional and physical health that the camp staff should be made aware. (Include behavior and activity adaptations and limitations i.e. behavior modification plans or strategies for behavioral or physical success in the camp setting.)
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Over the counter medications contained in our first aid kit that may be used to treat campers

1% Hydrocortisone, Ibuprofen, Low Level DEET Insect Repellent, PABA Free Sunscreen SPF 15/35, Antibiotic Ointment, Benedryl, Tylenol, Tums/7-up, Saline eye solution, Throat Lozenge, Chloraseptic, Calamine Lotion, Skin Moisturizer given according to package instructions.

Name of family physician ____ Phone ____________________

Name of family dentist ____ Phone ____________________

Name of orthodontist ____ Phone ____________________

Other ____ Phone ____________________