CAMPER'S NAME ________________________________

HIGHLAND MEDICAL INFORMATION FORM

TODAY'S DATE: ____________ SESSION NAME ___________________ SESSION DATE __________

Having adequate information about your child is crucial to our ability to provide a supportive environment. We rely on you to tell us what we need to know about your camper. Please contact the camp if your child has a chronic illness or disease to determine if our camp program is suitable for your child's medical condition. Our camp healthcare staff and leadership staff, the child's counselor (when appropriate) and if necessary, emergency medical personnel and insurance companies have access to information on this form.

.

CHRONIC HEALTH CONCERNS OR DISEASES: Check all that apply and if applicable describe below.

This camper has:

☐ NO CHRONIC HEALTH CONCERNS and is capable of FULL PARTICIPATION in the camp program

This camper has the following **CHRONIC ILLNESSES or DISEASES:**

☐ Arthritis and Rheumatologic Conditions - such as Juvenile Arthritis or Lupus

☐ Asthma

☐ Bones and Muscles - such as recent fractures and injuries

☐ Brain or Nervous System - such as Asperger Syndrome or Concussions or Cerebal Palsy or Seizures

☐ Cancer or Tumors

☐ Digestive System - such as Celiac Disease

☐ Ears or Nose or Throat or Speech or Hearing

☐ Emotional or psychiatric - such as depression or OCD or panic attacks

☐ Endorcine Glands and Growth or Diabetes

☐ Genetic or Chromosomal or Metabolic Condition

☐ Heart or Blood Vessels - including congenital heart defects or bleeding disorder

☐ Immune System

☐ Kidney and Urinary System - including bedwetting

☐ Learning Disorders - including Autism or ADHD

☐ Lung and Respiratory System

☐ Sexual and Reproductive System - including menstrual problems

☐ Sleep Disorders - including night terrors or sleepwalking

☐ Surgical History of Consequence

☐ Other

CAMPER'S NAME ________________________________

Describe your camper's chronic illness or disease and how you take care of it at home.

ALLERGIES: Check those that apply and if applicable describe below.

This camper has:

- [ ] NO KNOWN ALLERGIES

This camper has the following **KNOWN ALLERGIES:**

- [ ] Food - including gluten or food dyes
- [ ] Medications - including over-the-counter
- [ ] Insect venom - including things such as bees
- [ ] Enviromental - including things such as grass or pollen
- [ ] Other - describe below

Describe what this camper is allergic to; describe the reaction; and what is done to manage the reaction.

Does the reaction cause anaphylaxis and require the administration of an Epi-pen? ○ Yes ○ No

For known allergies that cause anaphylaxis, campers should bring their prescribed Epi-pens. Be sure epi-pens have not expired.

NUTRITIONAL NEEDS: Check all that apply and if applicable describe below

This camper:

- [ ] Eats a REGULAR DIET and is prepared to eat a variety of foods

This camper has the following **DIETARY NEEDS:**

- [ ] Semi-Vegetarian and DOES NOT eat pork or beef
- [ ] Pesco and DOES NOT eat pork or beef or chicken

CAMPER'S NAME ________________________________

☐ Lacto-ovo and DOES NOT eat beef or pork or chicken or seafood or fish

☐ Vegan and DOES NOT eat meat or seafood or eggs or dairy

☐ DOES NOT eat pork because of faith beliefs

☐ Food intolerances such as lactose or food additives etc

Describe your camper's dietary need:

Our kitchen and staff prepare a variety of foods. Prepare your camper so s/he is ready to try various food items. We can work with some medically prescribed diets but do not cater to individual food preferences. Call camp immediately to see if we are able to accommodate special dietary needs. In some situations, parents may be responsible for providing supplementary food for special diets.

IMMUNIZATION HISTORY - Provide a date for each immunization or send a copy of camper's immunization records to the camp. If you are unable to provide dates, see below:

Diphtheria, Tetanus, & Pertussis (DTap, DTP, or Tdap) ☐

HaemophilusInfluenzae Type b (Hib) Vaccine ☐

Hepatitis B Vaccine ☐

Human Papillomavirus Vaccine (HPV) ☐

Measles, Mumps, & Rubella (MMR) Vaccine ☐

Pneumococcal (PCV) Vaccine ☐

Polio Vaccine ☐

Varicella (Chickenpox) Vaccine ☐

If you are unable to provide dates for immunization history, check all that apply

☐ Camper attends a public school

☐ Camper is up to date on current immunizations

☐ Camper has not been immunized - please explain why

MEDICATIONS: ***Medications include any substance a person takes to maintain and/or improve their health.***

This camper:

☐ DOES NOT take any medications on a routine basis

CAMPER'S NAME ___________________________________

This camper:

☐ WILL TAKE the following medications while at camp

Name of medication #1 ☐

Reason for taking medication #1 ☐

Medication #1 to be given when:

☐ Before Breakfast ☐ After Breakfast
☐ Before Lunch ☐ After Lunch
☐ Before Supper ☐ After Supper
☐ Bedtime ☐ Other - please specify below

Name of medication #2 ☐

Reason for taking medication #2 ☐

Medication #2 to be given when:

☐ Before Breakfast ☐ After Breakfast
☐ Before Lunch ☐ After Lunch
☐ Before Supper ☐ After Supper
☐ Bedtime ☐ Other - please specify below

Name of medication #3 ☐

Reason for taking medication #3 ☐

Medication #3 to be given when:

☐ Before Breakfast ☐ After Breakfast
☐ Before Lunch ☐ After Lunch
☐ Before Supper ☐ After Supper
☐ Bedtime ☐ Other - please specify below

Name of medication #4 ☐

Reason for taking medication #4 ☐

Medication #4 to be given when:

☐ Before Breakfast ☐ After Breakfast
☐ Before Lunch ☐ After Lunch
☐ Before Supper ☐ After Supper
☐ Bedtime ☐ Other - please specify below

Name of medication #5 ☐

Reason for taking medication #5 ☐

Medication #5 to be given when:

☐ Before Breakfast ☐ After Breakfast

CAMPER'S NAME ___________________________________

- [ ] Before Lunch
- [ ] After Lunch
- [ ] Before Supper
- [ ] After Supper
- [ ] Bedtime
- [ ] Other - please specify below

Bring enough of each medication to last the entire session. Campers taking medication should be on the same medications at the same dose as prescribed by their physician. All medications must arrive in appropriately labeled pharmacy containers.

The following is a sample list of medications stocked in the health center. This camper **SHOULD NOT BE GIVEN:**

- [ ] Benadryl
- [ ] Calamine Spray
- [ ] Dimetapp
- [ ] Double Antibotic Ointment
- [ ] Hydrocortisone
- [ ] Ibuprofen
- [ ] Imodium
- [ ] Kaopectate
- [ ] Robitussin DM
- [ ] Tums
- [ ] Tylenol

MEDICAL INSURANCE:

Is the camper covered by medical insurance? ○ Yes ○ No

Medical Insurance Company: [ ]

Medical Insurance Company's Mailing Address [ ]

Medical Insurance Policy #: [ ]

Parents/guardians are financially responsible for health care given by an out of camp provider.

Insurance concerns can only be managed by parents/guardians and their insurance company. You may want to notify your insurance to determine if your insurance will work while your child is in our program and/or what you need to do should your child need healthcare.

HEALTH CARE PROVIDERS:

Camper's Physician's Name [ ]

Physician's Office Phone Number: [ ]

CAMPER'S NAME ________________________________

Camper's Dentist's Name:

Dentist's Office Phone Number:

Camper's Orthodontist's Name:

Orthodontist's Office Phone Number

Our healthcare provider will make every effort to contact you by phone if your child has need for out-of-camp healthcare. Because of timing and scheduling conflicts, we cannot promise that we will be successful in reaching you. The emergency phone numbers you provided when you registered your child will be used. Please be sure that we know how to reach you during your child's stay. If you have an answering machine, we will leave an appropriate message. We generally do not contact you if your child is seen by the nurse or healthcare provider for routine problems (e.g. skinned knees, sore throat, headache) that do not require a physician referral. This includes over-night stays in the health center. The decision to consult you in these situations is determined on a case-by-case basis by our healthcare provider. Please describe below if you want us to follow a practice different from what is described.

CONSENT and INDEMNITY:

In signing this document, I hereby certify that the above information is correct and give permission for the use of video/photographs including my son or daughter to be used in camp publicity and for Parent Communicator; for my son or daughter to be transported for approved out-of-camp activities; and for the release of medical records in the case of illness. The person herein described has permission to engage in all prescribed camp activities, except as noted below by me. In the event I cannot be reached, I hereby give permission to the physician selected by Highland Retreat staff to obtain proper medical diagnosis, hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above.

In consideration of permission granted the herein named individuals to participate in camping activities, we hereby covenant with Highland Retreat that we will never, individually, or as legal guardians of said individuals, institute any action at law or in equity for any personal injuries, or injuries to property, real or personal, caused by, or arising out of, camping and other related activities sponsored by Highland Retreat, its successors, and legal representatives; we further agree to indemnify and hold Highland Retreat harmless against any and all costs, damages, and expenses which may be occurred by them as a result of any lawsuits we might file against them.

Parent/Guardian Signature: ____

Date of Signature: _________________________

When you arrive for check-in, you will be asked to review medical information provided and physically sign the consent and indemnity statement. If you will not be present for check-in, please notify the camp in advance so the form can be mailed to you. Physical signatures are required for participation.

FOR OFFICE USE ONLY - MEDICAL INFORMATION FORM:

Medical Information Form initially reviewed on:

Medical Information Form initially reviewed by: Select...

Are there any health concerns requiring consultation with nurse manager? ○ Yes ○ No

CAMPER'S NAME ________________________________

Date reviewed by Nurse Manager: [ ]

Nurse Manager's Recommendation:

☐ Acceptance

☐ Conditional Acceptance

☐ Denial

HEALTH FORM INFORMATION AT CHECK-IN:

Are there any additions or corrections to information on the Health Information Form? ○ Yes ○ No

Medications to be given to health care staff? ○ Yes ○ No

History of exposure to communicable disease? ○ Yes ○ No

Any signs/symptoms of illness or injury upon arrival? ○ Yes ○ No

Do you wish to speak with the camp nurse? ○ Yes ○ No