Camp Gregory Medical History for Campers

Campers must bring this completed medical form to camp or they will not be allowed to attend.
This form will be maintained and filed in the Health Office at Camp Gregory by the Camp Health Director or the Camp Director.

Name _____ Age _____ Sex _____
Last First M.I.

Birth date _____ Height _____Weight _____

Parent, Guardian _____Phone (____)_____

Address _____ Phone (____)_____

City _____State and Zip Code _____

Emergency contact person (If Parent or Guardian is not available)

Name _____Phone (day) _____(n) _____

Name _____Phone (day) _____(n) _____

HEALTH HISTORY

Immunizations--Please give dates of last inoculation or booster. Tetanus must be less than ten years old

Polio OPV (Sabin)	**Tuberculin**	**Varicella**
MMR #1	**DTP or TD Booster (most recent)**	**Meningococcal (MenACWY)**
MMR #2	**Hepatitis B**	**haemophilus influenza type b**

Illnesses: Please check any of the following that your child (campers) has had or that you (staff) have had

___Ear Infections ___Epilepsy ___Convulsions
___Diabetes ___Swimmer's Ear ___Asthma
___Hay Fever ___Severe Allergy (Please see below)

Allergies: Please describe all allergies to any substance (i.e.. : foods, medicines, environments., chemicals, plants, insect stings, etc.)

Allergy	Symptoms	Treatment

For Campers and Staff/volunteers under 18 years old:

This health history is correct and complete as far as I know and my child (named above) has permission to engage in all camp activities(including swimming in the lake) except as noted I understand that all medications are required to be in the original container and that prescribed medicine must have the pharmacy label attached. ***ALL medication is to be turned into the Health Director at registration.*** My child's medicine will be made available to my child according to the enclosed dosage schedule. I confirm that my child is capable of taking his/her own medication. I grant permission for my child to have the medications noted on the medicine list and allow staff to put insect repellent and/ or sunscreen on my child at their request.

I give permission to the camp to provide routine health care and see emergency medical treatment and/or transport as needed. In the event I cannot be reached, I give the camp permission to provide my child's medical record to emergency medical personnel and give permission to the health care provider (MD, NP, PA, etc) selected by the camp to treat my child as deemed necessary until I can be reached.

I give permission for my child (named above) to carry and self apply sunscreen and/or insect repellent. I understand that the following conditions must be met in order to promote proper and safe use of sunscreen and insect repellent at Camp Gregory:

1) The sunscreen will only be used to prevent overexposure to the sun
2) The insect repellent will only be used to prevent insect bites
3) Only Sunscreen approved by the FDA for over the counter use will be permitted to be used by the camper.

If my child (named above) is unable to apply the sunscreen and/or insect repellent themselves I give permission for the camp staff to assist in the application of the sunscreen and/or insect repellent.

Parent signature _____ Date. _____

MEDICATION

Over The Counter Medicines: Please list any over the counter medicine that is taken regularly. The first three medicines in the list are available at the camp infirmary for use as needed. If a camper uses these regularly then please send them with the camper in the original packaging/container. Please indicate permission for these to be given, if necessary by marking Yes and signing the list column. Dosing/Schedule can not exceed label instructions without doctors approval.

Over the Counter Medicine	Route	Dosage	Schedule & Indications	Permission	Parent Signature
Tylenol (acetaminophen)					
Motrin (ibuprofen)					
Benadryl (Diphenhydramine)					

Prescription Medicine: Please list all prescription medicines taken: All Prescription medicines MUST be in ORIGINAL pharmacy containers with the correct and current pharmacy label on the container.

Prescription Medicine	Route	Dosage	Schedule/Indications	Comments

SPECIAL CONSIDERATIONS: Please list any recent operations (give dates), serious injuries or other conditions that require special attention or awareness.

PHYSICAL EXAMINATION

This examination should be performed within 1 year prior to arrival at camp. Please have the health care provider (personal physician, school nurse, etc.) sign below verifying physical exam. School examination or examination for some other purpose is acceptable. Examination is for determining the individual's fitness to engage in strenuous activities.

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities, except as noted (see first page).

_____ _____

Signature of Examining Physician or School Nurse **Date**

_____ _____

Address **Telephone**

_____

City. / State / Zip Code **02/3/24**