Sequanota Lutheran Conference Center and Camp Medical Form

PO Box 245, Jennerstown, PA 15547 phone: (814) 629-6627 fax:(814) 629-0128

To Parent(s)/Guardians(s): Complete this section and give **this form** to your child's health-care provider for review.

Camper Name:_____ ☐ Male ☐ Female Birth Date:_____ Age:_____

Camper home address: _____

Custodial parent(s)/guardian(s) phone: (_____)_____ (_____)_____

The online health history is correct as far as I know, and the person herein described has permission to engage in all camp activities except as noted. Emergency Authorization: I hereby give permission to medical personnel selected by the camp director to order x-rays, routine tests, treatment; to release any records necessary for insurance purpose; and to provide or arrange necessary related transportation for me/or 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 above. This completed form may be photocopied for trips out of camp.

SIGNATURE OF PARENT/GUARDIAN OR ADULT CAMPER/STAFF_____

The following non-prescription medications are commonly stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. **Medical personnel: Cross out those items the campers should not be given.**

- Acetaminophen (Tylenol)
- Ibuprofen (Advil, Motrin)
- Chlorpheneramine maleate
- Guaifenesin
- Dextromethorphan
- Diphenhydramine (Benadryl)
- Generic cough drops
- Chloraseptic (sore throat spray)
- Lice shampoo or scabies cream (Nix or Elimite)
- Bismuth subsalicylate (Pepto-Bismol)
- Laxatives for constipation (Ex-Lax)
- Hydrocortisone 1% cream
- Topical antibiotic cream
- Calamine lotion
- Aloe

Medical Personnel: Please complete this form. Attach additional information as needed.

Physical Exam done today: ☐ Yes ☐ No (If no, date of last physical: _____)

ACA accreditation standards specify physical exam within last 12 months.

Weight _____lbs Height _____ft_____in Blood Pressure_____/_____

Allergies: ☐ No Known Allergies

☐ To foods (list):

☐ To medications (list):

☐ To environment (insect stings, hay fever, etc.):

☐ Other allergies (list):

Describe previous reactions:

Diet, Nutrition: ☐ Eats a regular diet. ☐ Has a medically prescribed meal plan or dietary restrictions: (describe below)

The camper is undergoing treatment at this time for the following conditions: (describe below) ☐ None.

Medications: ☐ No daily medications ☐ Will take the following prescribed medication(s) while at camp: **(name, dose, frequency)**

Other treatments/therapies to be continued at camp: (describe below) ☐ None needed.

Do you feel that the camper will require limitations or restrictions to activity while at camp? ☐ No ☐ Yes

If you answered "Yes" to the question above, what do you recommend? (describe below—attach additional information if needed)

"I have reviewed the camper's health history and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)

Name of licensed provider (please print) _____ Signature: _____ Title:_____

Office address_____

Phone: (_____)_____ Date:_____

reviewed 1/2017