CAMPER HEALTH FORM 2009
CAMP MOWANA

Mail to: Camp Mowana
2276 Fleming Falls Rd.
Mansfield, Ohio 44903
(419)589-7406 Fax: (419)589-3096

OFFICE USE
Counselor:______________________________
Cabin:______________________________

Camper Name:______________________________
Birthdate:__________________ **Gender:**__________ **Age:**________
Program Name:__________________________ **Dates/Year**________

Parent/Guardian:__________________________________ **Phone: ( )**______________________
Address:____
City:__________________________ **State:**____________ **Zip:**______________________
Work Phone: ( )__________________________ **Pager #: ( )**______________________
Fax:( )____________________ **Email:**____________________ **Cell Phone: ( )**______________

Health Insurance Company:______________________ **Policy or Group #**______________________
Name of parent carrying Health Insurance:__________________ **Parent SS#**__________________
(Please attach a photocopy of your insurance card)

If not available in an emergency, notify:
Name:____ **Phone: ( )**______________________

Name:____ **Phone: ( )**______________________

Name of Physician:______________________________________ **Phone: ( )**______________________

Chronic Problems:
______Ear Infections
______Asthma
______Diabetes
______Headaches
______Bedwetting
______Sleepwalking
______Learning Disability
______Psychiatric Care
______Seizures
______ ______________
______None

Allergies
______Food
______Medication
______Penicillin
______ ______________
______Insect Stings
______Hay Fever
______Other (Specify):
____
______None

Immunization Record:
DPT series [ ]
Mumps [ ]
Measles [ ]
Rubella [ ]
Polo Series [ ]
Hepatitis B series [ ]
Tetanus Booster __________
(Date required)

HEALTH HISTORY: To be completed by Parent/Guardian.

Describe management of chronic problems and/or allergies:
____
____
____ None:________

Describe past medical treatments, surgeries, hospitalizations, injuries, special restrictions, or other considerations while at camp:____
____
____ None:________

Describe treatment your child receives for emotional, learning, or psychological concerns:____
____
____ None:________

If camper is female, has she begun menstruation?______if not, has she been told about it?______
If so, is her menstrual history normal?_____ Special considerations:
____ N/A:________

Dietary Restrictions:____
____ None:________

Is your child a vegetarian?	yes	no
Has your child ever been to camp before?	yes	no
Has your child ever been homesick?	yes	no
Does your child wear glasses/contacts?	yes	no
Does you child have braces?	yes	no
Does your child wear a retainer?	yes	no
Has your child had chicken pox?	yes	no

Please use this space to provide any other information about your child's health:
____
____

(over)

PARENT/GUARDIAN AUTHORIZATIONS:

CAMP MEDICATIONS:

The following list includes over-the-counter medications recommended by our camp doctor. These are available to treat minor afflictions as listed below. The dosage is determined according to the size/age of child, and the specific directions listed on the medication. Please indicate whether or not these treatments may be given for each condition listed. *Reminder: Camp staff will contact you immediately if illness develops or emergency treatment is required!*

YES	NO	MEDICATION	CONDITION
____	____	Acetaminophen (Tylenol)	Relief of minor headache or fever
____	____	Tylenol Cold Formula	Relief of cold symptoms
____	____	Ibuprofen	Inflammation and Pain
____	____	Chloraseptic Spray	Sore Throat
____	____	Sore Throat Lozenges	Sore Throat
____	____	Sudafed	Relieve Congestion, runny nose
____	____	Antihistamine	Relieve allergic reactions
____	____	Kaopectate	Diarrhea
____	____	Mylanta, Tums, Pepto-Bismol	Nausea/Vomiting, Indigestion
____	____	Hydrogen Peroxide, Betadine/PhisoHex	Clean abrasions/cuts
____	____	Neosporin/antibiotic ointment	Treat abrasions/cuts
____	____	Noxema & Solarcaine	Treat/relieve minor burns
____	____	Sunscreen	Prevent Sunburn
____	____	Caladryl/Calamine Lotion	Poison Ivy
____	____	Hydrocortisone Cream	Poison Ivy
____	____	Nox-a-Sting, Cortaid, Sting-Eze	Insect bites/stings

OTHER MEDICATIONS to be taken while at camp:______________________________

____

(all medication MUST be sent in its original container Dosage and schedule form may be completed at registration THANKS!)

PERMISSION TO GIVE MEDICINE:

I hereby give permission for the camper previously named to receive the above over-the-counter medications as indicated at the direction and under the supervision of designated Camp Health Center staff.

Signature of Parent/Guardian:______________________________ **Date:**__________

PARENT'S PERMISSION:

I hereby give permission for my child to participate in all camp activities including challenge/ropes course, canoeing and off site field trips, except as previously noted. Further, I give permission for use of photos of my child to be used in camp promotion unless noted. My child will follow the rules of the camp and the directions of the camp staff.

Signature of Parent/Guardian:______________________________ **Date:**__________

AUTHORIZATION FOR TREATMENT:

I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to administer medication; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for 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 hopitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of Parent/Guardian:______________________________ **Date:**__________

CAMPER CHECKOUT:

When the normal camp session is complete, the following adult(s) will be picking up my child:

Name:______________________________ **Phone: (   )**__________________

Please call the camp office if this information changes before checkout time Thank you!

For Camp Use:

Date of Health Screening:______________ **Health Center Staff:**______________________