PARTICIPANT HEALTH FORM 2017

RETURN WITH YOUR BALANCE DUE AT LEAST 3 WEEKS PRIOR TO ARRIVAL (Keep a copy for your records)

Last Name: _____ **First Name:** _____ ☐ **Male** ☐ **Female**

Health Insurance: _____ **Birth Date:** _____ **Age:** _____

Policy #: _____ **I have no Insurance** ☐ **Grade** (As of May 2017)**:** _____

1. All camp participants (**including adults**) must have a physical exam within the last 24 months prior to arriving at camp. Please attach a copy of that exam, if available. If you have not had an exam in the last 24 months, you must schedule one at least 3 weeks prior to camp.
2. All camp participants must also complete the Colorado Health Depart. Certification of immunization (available on our website). For out-of-state participants who may not be up-to-date for CO standards, the parent/guardian/adult may sign the personal exemption section.
3. **All camp participants must complete this health form, including a parent/guardian/adult signature and a doctor's signature on the back of this form.**
4. Any camper with medications must list each medication separately (this includes prescription, over-the-counter, and vitamins) on the back of this form. A doctor must complete the medication portion of the health form.
5. Please mail/fax/email to the Sky Ranch office **no later than 3 weeks prior to your camp arrival.** Call with any questions: 970-493-5258 (office) 970-493-7960 (fax)

HEALTH HISTORY

Does the camper have a history of any of the following? (Check all that apply)

__ Seizures/Convulsions	__ Diabetes	__ Cancer/Leukemia	__ Mononucleosis	__ ADD/ADHD
__ Fainting/Dizzy Spells	__ Heart Disease/Defect	__ Bleeding/Clotting Disorder	__ Altitude Sickness	__ Asthma
__ Head Injury	__ High Blood Pressure	__ Menstrual Problems	__ Sleepwalking	__ Bi-Polar
__ Frequent Headaches	__ Frequent Ear Infections	__ Kidney Disease	__ Eating disorder	__ _____

Please explain any history that may impact the camper's experience or special care that should be taken _____

MENTAL HEALTH

In order to keep your camper safe, is there any mental health history we should be aware of? (Please describe below)

ASTHMA & ALLERGIES

PLEASE Complete additional Asthma &/or Allergy Health Care Form (Epi Pen Action Plan).
Campers &/or counselors will be allowed to carry asthma inhalers & epi pens.

__ No known Allergies __ Foods _____ __ Insect Stings_____
__ Medications _____ __ Other _____

SPECIAL DIET

__ Vegetarian __ Gluten Free __ Lactose Free Please describe any special dietary restrictions or requirements:_____

MEDICATION INSTRUCTION

1. All medications (prescriptions, over-the-counter, and vitamins) MUST be documented with accurate directions on the next page by a physician or registered nurse.
2. **All prescription medications, over-the-counter medications, and vitamins MUST be in original, non-expired container with current accurate directions and dosage.**
3. Pill minders, plastic bags, etc, are not acceptable for any medication.
4. Campers will be allowed to carry asthma inhalers & epi pens with them. Please fill out Asthma/Epi Pens action plan forms. You can attach asthma/epi pens action plans forms used for the school year as well.

STOCK OVER-THE-COUNTER MEDICATIONS

These are the over-the-counter medications stocked in the health clinic at Sky Ranch. These medications are overseen and administered by our volunteer health supervisor.

Please check off any medications that YOU DO NOT APPROVE and initial here:

CROSS OFF IF NOT APPROVED

Acetaminophen/Tylenol (headache)	Alcohol Wipes (skin cleansing)	Aloe Vera Gel (sun burn)
Anbesol (tooth/gum pain)	Ammonia Inhalants (fainting)	Antacid/Tums (upset stomach)
Aquaphor	Atibiotic Ointment (scrapes)	BSK Wipes (antiseptic wipes)
Calamine Lotion (rashes, insect bites)	Campho-Phenique (cold sores)	Cold Pack/ Ice
Cough Drops	Cough Syrup	Diphen/Benedryl (allergy, itching, rashes)
Emergen-C	Hydrocortisone CR	Heat Pack/Pad
Ibuprofen/Advil	Imodium (anti-diarrhea)	Instal-Glucose (insulin reactions)
Moleskin	Saline eye wash	Sunscreen
Psuedoval/Sudafed (congestion)	Gold Bond Powder	Bio Freeze

PARTICIPATION HEALTH FORM 2017

A PHYSICIAN OR LICENSED NURSE PRACTITIONER MUST COMPLETE & SIGN THIS PAGE ALONG WITH PARENT SIGNATURE

LAST NAME: _____ **FIRST NAME:** _____

MEDICATION INSTRUCTIONS (IF APPLICABLE)

1. All medications (prescriptions, over-the-counter, and vitamins) **MUST** be documented with accurate directions listed below. Please make sure that a physician or licensed nurse practitioner fills out medications.
2. **All prescription medications, over-the-counter, and vitamins MUST be in the original, non-expired container with current accurate directions and dosages.**
3. Pill minds, plastic bags, etc, are not acceptable for any medication.
4. Campers/counselors will be allowed to carry asthma inhalers & epi pens with them. Please fill out the Asthma and Epi Pen action plan forms. Campers can attach any school asthma/epi pen action plan form if current.
5. We encourage that if your camper takes commonly used over-the-counter medications **on an occasional basis**, like those for pain and allergies, that you leave them at home. We stock these medications on site.
6. If your camper takes over-the-counter medications **on a daily basis,** please list below.

Please provide the following information for EACH medication you are bringing to camp, including vitamins and over-the-counter medication.

MEDICATION #1

Medication Name (EXACT NAME) _____ Dosage (mg/ml & tab/capsule) _____

Administration Time: ☐ As Needed ☐ AM ☐ PM ☐ Other _____ ☐ Taken with Food

Reason for Giving _____

MEDICATION #2

Medication Name (EXACT NAME) _____ Dosage (mg/ml & tab/capsule) _____

Administration Time: ☐ As Needed ☐ AM ☐ PM ☐ Other _____ ☐ Taken with Food

Reason for Giving _____

MEDICATION #3

Medication Name (EXACT NAME) _____ Dosage (mg/ml & tab/capsule) _____

Administration Time: ☐ As Needed ☐ AM ☐ PM ☐ Other _____ ☐ Taken with Food

Reason for Giving _____

MEDICATION #4

Medication Name (EXACT NAME) _____ Dosage (mg/ml & tab/capsule) _____

Administration Time: ☐ As Needed ☐ AM ☐ PM ☐ Other _____ ☐ Taken with Food

Reason for Giving (Special Instructions) _____

PARENTAL OR GUARDIAN RELEASE

- I approve of the over-the-counter medications listed on the front page for use as needed by the camper identified above. I have crossed off any medications that are not approved for use by said camper.
- I hereby request and give my permission to the Sky Ranch Lutheran Camp heath supervisor to administer medication to the camper identified above. I understand that all medications must be provided in the original pharmacy labeled container. I understand my child assumes responsibility for going to the health clinic at specified times for medications.
- I hereby give my permission to Sky Ranch Lutheran Camp to give care to the camper identified above in case of illness or injury and understand Sky Ranch Lutheran Camp will attempt to contact me in such event.

_____ _____

Signature of Parent, Guardian, or Adult Participation **Date**

PHYSICIAN OR LICENSED NURSE PRACTITIONER RELEASE

- I have approved the medications and dosages listed above for use by the camper identified above.
- I approve the stock over-the-counter medications listed on the front page for use as needed by the camper identified.
- I have examined the camper listed above within the last 24 months and have reviewed the health history. It is my opinion that this camper is in satisfactory condition and capable of engaging in all camp activities, unless noted otherwise.

_____ _____

Signature of Physician or Licensed Nurse Practitioner **Date**

Printed Name _____ Phone Number _____

Printed Address _____