



# PARTICIPANT HEALTH FORM 2012

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 \_\_\_\_\_

Entered \_\_\_\_\_  
 Scanned \_\_\_\_\_  
 Last: \_\_\_\_\_  
 First: \_\_\_\_\_  
 Week: \_\_\_\_\_  
 Program: \_\_\_\_\_  
 Church: \_\_\_\_\_

- 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 three weeks prior to your arrival.
- All camp participants must also complete the Colorado Health Department Certification of immunization (available on our website). For out-of-state participants who may not be up-to-date for Colorado standards, the parent/guardian/adult may sign the personal exemption section.
- All camp participants must complete this health form, including **listing each medication separately** (including over-the-counter and vitamins; the second page is available if needed), **a parent, guardian, or adult signature, and a doctor's signature.**
- Please mail to the Sky Ranch office no later than 3 weeks prior to your camp arrival. Call our office with any questions: 970-493-5258.

## HEALTH HISTORY

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

- |  |  |   |  |                                     |
|--|--|---|--|-------------------------------------|
| <input type="checkbox"/> Seizures / Convulsions  | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Cancer / Leukemia            | <input type="checkbox"/> Mononucleosis     | <input type="checkbox"/> Asthma     |
| <input type="checkbox"/> Fainting / Dizzy Spells | <input type="checkbox"/> Heart Disease / Defect  | <input type="checkbox"/> Bleeding / Clotting Disorder | <input type="checkbox"/> Altitude Sickness | <input type="checkbox"/> ADD / ADHD |
| <input type="checkbox"/> Head Injury             | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Menstrual Problems           | <input type="checkbox"/> Sleepwalking      | <input type="checkbox"/> Bi-Polar   |
| <input type="checkbox"/> Frequent Headaches      | <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Kidney Disease               | <input type="checkbox"/> Eating Disorder   | <input type="checkbox"/> _____      |

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

## ALLERGIES

- 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

- All prescription medications, over-the-counter medications, and Vitamins **MUST be in the original container with current accurate directions.**
- Pill minders, plastic bags, etc, are not acceptable for any medication.
- Place all medication containers together in a plastic zip-lock bag with the camper's name on it.
- Campers are responsible for going to the infirmary at specified times for medication.
- Campers will be allowed to carry asthma inhalers & epi pens with them.

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

### MEDICATION #1

Medication Name: \_\_\_\_\_  
 Reason for Giving: \_\_\_\_\_  
 Frequency Given:  As Needed  Daily \_\_\_\_\_ time(s) per day  
 Dosage: \_\_\_\_\_  Taken with Food  
 Special Instructions: \_\_\_\_\_

If you have more than one medication, there is an additional medication page. Please check here if you have more than one page.

## Over-the-Counter medications

These are the over-the-counter medication 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 \_\_\_\_\_.

- |   |   |
|---|---|
| <input checked="" type="checkbox"/> <b>IF NOT APPROVED</b>      | <input checked="" type="checkbox"/> <b>IF NOT APPROVED</b>            |
| <input type="checkbox"/> Acetaminophen / Tylenol (headache)     | <input type="checkbox"/> Diphen / Benedryl (allergy, itching, rashes) |
| <input type="checkbox"/> Alcohol Wipes (skin cleansing)         | <input type="checkbox"/> Hydrocortisone CR                            |
| <input type="checkbox"/> Aloe Vera Gel (sun burn)               | <input type="checkbox"/> Ibuprofen / Advil (muscle cramps)            |
| <input type="checkbox"/> Ambesol (tooth / gum pain)             | <input type="checkbox"/> Imodium (anti-diarrhea)                      |
| <input type="checkbox"/> Ammonia Inhalants (fainting)           | <input type="checkbox"/> Instal-Glucose (insulin reactions)           |
| <input type="checkbox"/> Antacid / Tums (upset stomach)         | <input type="checkbox"/> Moleskin                                     |
| <input type="checkbox"/> Antibiotic Ointment (scrapes)          | <input type="checkbox"/> Saline eye wash (eye irritation)             |
| <input type="checkbox"/> Calamine Lotion (rashes, insect bites) | <input type="checkbox"/> Sunscreen                                    |
| <input type="checkbox"/> Campho-Phenique (cold sores)           | <input type="checkbox"/> Iodine Wipes (skin cleansing)                |
| <input type="checkbox"/> Cold Pack / Ice                        | <input type="checkbox"/> Pseudoval / Sudafed (congestion)             |
| <input type="checkbox"/> Cough Drops                            |   |

By signing below, you approve the administration of these over-the-counter medications for the camper listed above.

## PHYSICIAN OR LICENSED NURSE PRACTITIONER RELEASE

- I have approved the medications and dosages listed above (and on the additional medication page if necessary) for use by the camper identified above.
- I approve the over-the-counter medications listed above 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 option that this camper is in satisfactory condition and capable of engaging in all camp activities, unless noted above.

Signature physician or licensed nurse practitioner

Date

Printed Name \_\_\_\_\_ Phone Number \_\_\_\_\_

## PARENTAL OR GUARDIAN RELEASE

- I approve of the over-the-counter medications listed above for use as needed by the camper identified above. I have checked 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 health supervisor to administer medication to the camper identified above. I understand that all medication must be provided in the original pharmacy labeled container. I understand my child assumes responsibility for going to the health clinic at the 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 and understand Sky Ranch Lutheran Camp will attempt to contact me in such event.

Signature of Parent, Guardian, or Adult Participant

Date