

CAMPER'S HEALTH HISTORY

CAMPER NAME: _____
Last First Middle Age Girl Boy

About health care:

- At minimum, a staff member with first aid and CPR certification is at camp when campers are present.
- Campers should arrive ready to participate in the program. Should your camper be unable to participate a parent will be notified and the camper will remain under staff supervision until the camper is picked up by parent.
- Campers should bring – and use – insect repellent and sunscreen (minimum 30 SPF).

The following non-prescription medications may be stocked in the camp First Aid Center and are used on an as needed basis to manage illness and injury. These medications are administered by first aid personnel only.

Cross out those the camper should not be given.

- | | |
|---|--------------------------------|
| Acetaminophen (Tylenol) | Ibuprofen (Advil, Motrin) |
| Phenylephrine decongestant (Sudafed PE) | Antihistamine/allergy medicine |
| Pseudoephedrine decongestant (Sudafed) | Sore throat spray |
| Guaifenesin cough syrup (Robitussin) | Antibiotic cream |
| Diphenhydramine antihistamine/allergy medicine (Benadryl) | Calamine lotion |
| Dextromethorphan cough syrup (Robitussin DM) | Generic cough drops |
| Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol) | Aloe |

MEDICATIONS BEING TAKEN

Please list all medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage and the frequency of administration.

This person takes NO medications on a routine basis. OR This person takes medications as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____

Reason for _____

Med #2 _____ Dosage _____ Specific times taken each day _____

Reason for _____

Identify any medications taken during the school year that participant does/may not take during the summer: _____

Can Tylenol be given to your camper? Yes No If YES, recommended dosage: _____

Date (month & year) of your child's most recent tetanus immunization _____

Is camper allergic to: (Please check the appropriate box)

- Bee Stings Other bites Penicillin Food Allergies (list) _____
- Hay Fever Animal Dander Environmental allergies Other

Does this child have asthma? Yes No

If YES, will your child carry a rescue inhaler during the camp session? Yes No

If YES, does your child need staff help to use that rescue inhaler? Yes No

If YES, what triggers your child's asthma? Yes No

Name of family physician _____ Phone _____

Insurance Information:

Is the participant covered by family medical/hospital insurance? Yes No

If so indicate carrier or plan name _____ Group # _____

We will call when there is a question about your child's health and/or in an emergency. Provide contact information for a custodial parent who will be available via phone while your child is attending our program.

Name of Parent _____ Phone () _____

Important – this box must be complete for attendance

This health history information is correct and the child described has permission to participate in all camp activities except as noted on this form. I understand that the camp has limited healthcare on site and that staff will call the indicated parent/guardian (a) in an emergency, (b) if questions about my child's health may arise, and /or (c) when my child is unable to continue because of injury or illness. I acknowledge that the program will handle medication as described and that information on this form will be shared with staff on a need-to-know basis.

I grant permission for my child/ward to attend Mother of Hope Camp and agree to release, exonerate, indemnify, and defend the Roman Catholic Bishop of Providence, Catholic Youth Organization of the Diocese of Providence and Mother of Hope Camp from all claims arising from or occasioned by my child/ward/s attendance at the Camp. In consideration of admittance, I authorize the Mother of Hope Camp to arrange for medical examination and/or treatment for my child should an emergency arise at camp. It is understood that a conscious effort will be made by the Camp to contact me at the emergency number I have provided before any medical action is taken.

Signature of Parent/Guardian: _____ Date: _____

Printed Name: _____

