HEALTH INFORMATION FORM
BALTIMORE-WASHINGTON CONFERENCE CAMPS

DUE 2 weeks prior to your camp start day
Please BRING ORIGINAL with CAMPER!

All pages MUST be completed and there MUST be a parent/guardian signature.

PLEASE PRINT ONE CAMPER PER FORM

By all possible means please attempt to use the Camp Doc Electronic Medical Records portal with camper assigned username and password. If you are unable to do that complete this medical form and supporting material and fax to camp at 410-867-0991. ***If no/incomplete medical information is collected this will prevent camper from being able to attend the event****.*

CAMPER INFORMATION **Program**____________________ **Dates of Camp**________________

Camper Last Name______________________First Name______________________Date of Birth____________

Grade Entering: ___________ Age ______ Gender: ☐Male ☐Female

Physical Home Address:___________________________________ City:_________________ St______ Zip__________

County_____________________________________ School District ____

How did you hear about camp? ☐ Friend ☐ Ad ☐ Website ☐ Church (Name of church:_________________________)

Are you are returning camper? ☐ Yes ☐ No ☐ 1st time camper

Camper Roommate Request (please list 2 names)
____
____

Parent/Guardian with legal custody to be contacted in case of illness or injury:

Name:____Cell Phone #______________________

Relationship to Camper____

Home Address____ Phone #__________________________

Email Address____ Phone #________________________

Parent/Guardian Name or Emergency Contact Name__________________________Cell Phone #_________________

Relationship to Camper____

Home Address____ Phone #________________________

Email Address____Phone #________________________

If neither of the above is available in an emergency, notify:

Name____ Cell Phone # ___________________

Address____ Phone #_______________________

Primary Care Physician/Clinic_____________________________________**Phone #**___________________

DIETARY NEEDS *Please check yes for all appropriate and add any details that will help our staff better serve your child.*

☐ Vegetarian ☐ Vegan ☐ Dairy Free ☐ Gluten Free ☐ Other

____

ALL ALLERGENS (Foods/Medications/Environmental) *Please note if your child has an anaphylaxis risk to any allergen, they must bring an epi-pen to camp. They will not be admitted without an epi-pen available. If your child has environmental allergies, please list them and we recommend you bring medications along with all documentation and doctor's signature, so they are comfortable during their stay at camp.*

Anaphylaxis Risk

☐ YES ☐ NO ________________________ ____
Allergy Reaction

☐ YES ☐ NO ________________________ ____
Allergy Reaction

☐ YES ☐ NO ________________________ ____
Allergy Reaction

[Type here]

GENERAL HEALTH INFORMATION

Is camper a diabetic? ☐ Yes ☐ No *If you answer, yes to either diabetic or asthmatic – please contact our offices*
Is camper asthmatic? ☐ Yes ☐ No *for additional forms your doctor needs to complete.*

Ever been hospitalized? ☐ Yes ☐ No
Ever had surgery? ☐ Yes ☐ No
Recurrent/Chronic illness? ☐ Yes ☐ No
Recent Infectious disease? ☐ Yes ☐ No
Recent Injury? ☐ Yes ☐ No
Had seizures? ☐ Yes ☐ No
Had headaches? ☐ Yes ☐ No
Wear Glasses/contacts? ☐ Yes ☐ No
Any skin problems? ☐ Yes ☐ No

Had fainting or dizziness? ☐ Yes ☐ No
Passed out/had chest pain during exercise? ☐ Yes ☐ No
Had mononucleosis "mono" in past 12 months? ☐ Yes ☐ No
Have problems falling asleep/sleepwalking? ☐ Yes ☐ No
Ever had back/joint problems? ☐ Yes ☐ No
Had history of bedwetting? ☐ Yes ☐ No
Have problems with diarrhea/constipation? ☐ Yes ☐ No
Traveled outside the country in past 9 months? ☐ Yes ☐ No
If yes, where/when:________________________________
If female, been told about periods/menstruation? ☐ Yes ☐ No
Any issues with periods/menstruation? ☐ Yes ☐ No

*If any answers are yes, please explain futher*____
____
____

BEHAVIORAL/MENTAL/EMOTIONAL/SOCIAL HEALTH *We desire the very best experience for your child, please complete the following question pertaining to development, behavioral and emotional needs of your child. Please answers these questions fully so that we will be prepared to meet the specific needs of your camper. The more information we have prior to the start of camp the better we can respond to your child's needs.*
Has camper been treated or is dealing with any of the following:

Attention Deficit Disorder (ADD)/ Attention Deficit Hyperactivity Disorder (ADHD) ☐ Yes ☐ No
Emotional or behavioral difficulties? ☐ Yes ☐ No
Eating Disorders? ☐ Yes ☐ No
Anxiety/Depression/Trauma? ☐ Yes ☐ No
During the past 12 months, seen a professional to address mental/emotional health? ☐ Yes ☐ No
Any significant life event that continues to affect the camper's life? ☐ Yes ☐ No
(i.e. history of abuse, death of loved one, family change, divorce, new sibling, other?)

If any answers are yes, please explain further and include any known triggers ___________________________________
____
____

The Health Care Provider will administer the following over the counter medicines or the generic equivalents that are available at camp for the nurse/health aide to use as needed. Dosages will be administered according to package directions. **Only acetaminophen, cough drops and topical medicines such as antibiotic ointment, can be given more than once without a signed physician order.** If there is a specific medication listed below that your camper cannot have, please select and give details of specific reactions.

Symptom	Medication	Symptom	Medication
Minor aches/pain/fever	Acetaminophen/ibuprofen	Minor cough/Sore throat	Cough drops
Minor allergic reactions/allergies	benedryl/Zyrtec/(non-drowsy)	Poison Ivy/Rashes	Calagel Lotion/IvyDry
Diarrhea	Kaopectate	Bug Bites	Benzocaine Swabs
Indigestion/heartburn	Antacid	Motion sickness	Dramimine/Dimenhydrinate
Constipation	Collace/Miralax/Pedilax	Jelly Fish Stings (WR)	Vinegar/ hydrocortisone cream
Clogged Ears	Auro-Dry	Mild Burns	Aloe
Eye Wash	Saline	Bleeds	Compression/bleed cease

[Type here]

SUNSCREEN/BUGSPRAY

Use of sunscreen/bug spray are critical for camper safety but also presents a light chance for allergic reaction. State of MD requires parents to **notify us of the BRAND NAME** your camper may use and **if our staff camp assist your camper in applying.**

My camper can use _______________ sunscreen & ________________ bug spray that they have brought to camp. **Staff may assist in application upon request:** Yes ❑ No ❑

PERMISSION TO PARTICIPATE and TRAVEL

Campers are encouraged to participate in all camp activities. Specialized activities are listed below and those that are site specific are designated. All specialized activities are led by trained and certified staff. Some activities are dependent upon age level, site, and program and will not be offered to all campers. Some activities happen off-site. Campers will be transported by passenger vans or buses with licensed drivers age 21 or older. (M-Manidokan, W-West River)

Swimming, Rafting (M), Kayaking/Canoeing, Hiking, Low Ropes, High Ropes, Climbing Wall, Field Games, Team Sports, Rappelling, Motorboat rides (W), Fishing (W), Sailing (W), Zip Line (M), Giant Swing (W), Archery, Tubing (W), Biking (W), Horseback Riding (M)

By signing below you fully acknowledge and understand that risks and dangers exist in participating in these specialized camp activities. These risk and dangers may be caused by other participants, by accidents, or by forces of nature or other causes. By signing below you accept and assume these risks and dangers.

If for some reason your child cannot participate in any of these activities please list activity and reason below.

____

PERMISSION TO TREAT

By signing below, I acknowledge that I have read and understand all pages of this health form and all the information that I have provided is true to the best of my knowledge.

IN CASE OF EMERGENCY INVOLVING ______________________________: I understand every effort will be made to contact me or the persons I have named on this form. In the event I cannot be reached, I give permission to the Camp Manager/Director or their designee to seek and provide transportation to an emergency or medical facility as needed. I further grant permission to the medical personnel selected by the Camp Manager/Director or their designee to hospitalize, secure proper treat for, order x-rays, routine tests, to order injections and/or anesthesia and/or surgery and release any records as necessary for insurance purposes for the camper named above. This form may be photocopied for use away from camp.

I request the authorized youth camp operator/staff to administer authorized medications or supervise the camper in self-administration as prescribed. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period, an adult must pick up any medications provided to the facility, otherwise it will be discarded. I authorize camp personnel to communicate with the prescriber as allowed by HIPAA.

Signature of Parent or Guardian ________________________________ Date: _________

[Type here]

Camper Release Authorization:

Please at least 2 people that are authorized to sign out this camper at the end of the session, or anytime during the session due to illness or emergency- parents please include yourself if you are planning to pick up your child:

Name:____ Cell Phone:______________________________

Relationship to Camper: ____

Name:____ Cell Phone:______________________________

Relationship to Camper: ____

Name:____ Cell Phone:______________________________

Relationship to Camper: ____

If there is anyone who is strictly NOT authorized to sign out this camper due to family issues, legal concerns, ect. please give their name and if needed provide extra documentation.

Name:____ Cell Phone:______________________________

Relationship to Camper: ____

Attach a copy of current up-to-date INSURANCE CARD – FRONT and BACK.

Attach a copy of current up-to-date IMMUNIZATION RECORD.

Copy machines will NOT be available at camp.

REGULATIONS FOR MEDICATIONS (State Youth Camp Regulations Act)

All Prescription medication must be in original container labeled by the pharmacist or physician with:

Name of camper *Name of medication* *Dosage, route and time of administration*

Name of physician *Prescription date and expiration date* *Conditions for storage*

All medications must have been administered at least once at home with no problems.

A physician signature IS REQUIRED on this form for ALL medications.

Emergency medications (Inhalers, Epipens, etc.) that need to be closer to camper may be kept by the immediate counselor. Two sets of medication must be brought to camp and the camper must be able to self-administer and parents AND physician given permission as signed below.

SELF-ADMINISTRATION OF MEDICATIONS

According to the Youth Camp Regulations Act: Self-Administration of medications means the act of a camper ingesting, injecting or applying the camper's own nonprescription or prescription medicine when the individual identifies their own medicine and follows the directions for use including the correct route or dosage.

If campers are allowed to self-administer medications at summer camp:

- All medications will be turned in to the camp nurse/health aide and kept securely,

At the prescribed time campers will be handed their medication bottle/container and dispense the medication from the containers themselves. This is all done under the supervision of the camp medical staff or adult counselor. Permissio to self-administer must be signed by both doctor and parent on medication confirmation form

All Non-Prescription/Over-the-Counter (OTC) medication must be in the original sealed container with the label intact. Camper's name will be put on the container in a position that does not obscure the label. Except for acetaminophen and topical medicines, only one dose of medication is given unless the child's health practitioner approves an additional dose in writing. *(If more than one dose will be given at camp, physician's signature is required)*

☐ Check here if this camper takes **NO** medications on a routine basis.

Are there any medications taken during the school year that the camper does/may not take during the summer?

☐ No ☐ Yes Please give name of medication ____

Reason not taking medication during the summer: ____

[Type here]

For ALL Campers with Medications at:
Camp Manidokan, 1600 Harpers Ferry Rd, Knoxville, MD 21758 or West River Center, 5100 Chalk Point Rd, West River, MD 20778
Please copy a blank page if you have more medications for the doctor to complete. Forms with original signatures should come to camp with the camper.

For **ALL NON – PRESCRIPTION** and **PRESCRIPTION** medications (REQUIRES PHYSICIAN SIGNATURE).

Medication ______________________________
Diagnosis ______________________________
Strength______________ Route________________
Dosage _______________ Time of Admin (circle)
Breakfast Lunch Dinner Bedtime
Other ___________
Known side effects___________________________
If PRN for what symptoms? ____________________
Services begin _________ Terminate ____________
Is this an emergency medication? YES NO
____ Camper is able to self administer
____ Camper is NOT able to self administer

Medication ______________________________
Diagnosis ______________________________
Strength______________ Route________________
Dosage _______________ Time of Admin (circle)
Breakfast Lunch Dinner Bedtime
Other ___________
Known side effects___________________________
If PRN for what symptoms? ____________________
Services begin _________ Terminate ____________
Is this an emergency medication? YES NO
____ Camper is able to self administer
____ Camper is NOT able to self administer

Medication ______________________________
Diagnosis ______________________________
Strength______________ Route________________
Dosage _______________ Time of Admin (circle)
Breakfast Lunch Dinner Bedtime
Other ___________
Known side effects___________________________
If PRN for what symptoms? ____________________
Services begin _________ Terminate ____________
Is this an emergency medication? YES NO
____ Camper is able to self administer
____ Camper is NOT able to self administer

Medication ______________________________
Diagnosis ______________________________
Strength______________ Route________________
Dosage _______________ Time of Admin (circle)
Breakfast Lunch Dinner Bedtime
Other ___________
Known side effects___________________________
If PRN for what symptoms? ____________________
Services begin _________ Terminate ____________
Is this an emergency medication? YES NO
____ Camper is able to self administer
____ Camper is NOT able to self administer

Medication ______________________________
Diagnosis ______________________________
Strength______________ Route________________
Dosage _______________ Time of Admin (circle)
Breakfast Lunch Dinner Bedtime
Other ___________
Known side effects___________________________
If PRN for what symptoms? ____________________
Services begin _________ Terminate ____________
Is this an emergency medication? YES NO
____ Camper is able to self administer
____ Camper is NOT able to self administer

Medication ______________________________
Diagnosis ______________________________
Strength______________ Route________________
Dosage _______________ Time of Admin (circle)
Breakfast Lunch Dinner Bedtime
Other ___________
Known side effects___________________________
If PRN for what symptoms? ____________________
Services begin _________ Terminate ____________
Is this an emergency medication? YES NO
____ Camper is able to self administer
____ Camper is NOT able to self administer

Administration of above medications is approved by:
Physician Signature: ____ Date: ________________
Printed Name: ____ Phone # _____________ Fax ___________
Address: ____ City: ___________ St: ____ Zip: ________
Please sign and date to verify that you have given permission for the Nurse/Health Aide to administer the medications designated to your child.
Self-administration, if approved: I give permission for my child to self-administer the medication as listed according to package or doctor's directions. I acknowledge that my child has previously self-administered these medications at home under my supervision and has shown understanding and responsibility to do so at camp. I understand the definition of self-administer and am aware that all medications will be taken in the presence of the Nurse, Health Aide or Adult counselor. **Parent/Guardian Signature** ____________________ **Date** _________

[Type here]