HEALTH INFORMATION FORM **Please DO NOT MAIL this form!**
BALTIMORE-WASHINGTON CONFERENCE CAMPS **Please BRING TO CAMP 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 bring to camp at time of event. If no medical information is collected this will prevent camper from being able to attend the event.

CONTACT INFORMATION

Program_____ Dates of Camp_____

Camper Last Name_____First Name_____ Date of Birth_____
Gender: ☐Male ☐Female Hair Color: _____ Eye Color: _____Age _____Weight_____Height_____

Parent/Guardian_____Cell Phone #_____
Home Address_____ Phone #_____
Email Address_____ Phone #_____

Parent/Guardian Name or Emergency Contact Name_____Cell Phone #_____
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 #_____

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), 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.

_____

I give permission for the above named camper to travel to/participate in the listed activities except as noted.

Parent/Guardian Signature_____ Date_____

I understand and agree to abide with all safety regulations and rules set out by the counselors and instructors. I also agree to abide by any restrictions as noted above.

Camper Signature _____ Date_____

Camper Name_____ Camper Date of Birth_____

HEALTH INFORMATION

Are there any special dietary needs? _____

Are there any allergies? Food_____ Medicines_____

Environment_____ Other_____

Has this camper ever required any psychiatric counseling or hospitalization? _____

Please explain: _____

Sleepwalking? □ Yes □ No Bed-wetting? □ Yes □ No Soiling? □ Yes □ No

Has camper had any major operations/hospitalization/illnesses? _____

For Females Only: Has camper begun menstruation (period)? □ Yes □ No

Has she been told about it? □ Yes □ No

Please provide any pertinent information about the camper's behavior and physical, emotional, or mental health, which the camp should be aware of. *Use additional paper if needed*.

_____

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. Except for acetaminophen and topical medicines, only one dose of a nonprescription medicine is given unless the camper's health practitioner approves an additional dose in writing. If there is a specific medication listed below that your camper cannot have, please select.

Symptom	Medication	Symptom	Medication
Minor aches/pain/fever	Acetaminophen/ibuprofen	Minor cough/ Sore throat	Cough drops
Minor allergic reactions/allergies	Diphenhydramine	Poison Ivy/Rashes	Calagel Lotion
Diarrhea	Kaopectate	Bug Bites	Benzocaine Swabs
Indigestion/heartburn	Antacid	Motion sickness (WR)	Dramimine/Dimenhydrinate
Constipation	Milk of Magnesia	Jelly Fish Stings (WR)	Vinegar/meat tenderizer/ Baking soda/ or hydrocortisone cream
Clogged Ears	Auro-Dry		

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.

Signature of Parent or Guardian _____ **Date:** _____

Camper Name_____ Camper Date of Birth_____

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:

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 <u>INSURANCE CARD – FRONT and BACK</u>.

Copy machines will <u>NOT</u> 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.
<u>A physician signature IS REQUIRED on this form for ALL medications.</u>

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:

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

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: _____

Camper Name_____ Camper Date of Birth_____

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
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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** ____________

Camper Name______________________________ Camper Date of Birth____________________