



PARENT: Complete form INCLUDING Part VII – Parent Signature section on the back

PHYSICIAN: Complete Part VIII Record of Health Examination on back of form

PART I: CAMPER RECORD

Camper's Name - Last, First, Middle Initial Birth Date - MM/DD/YYYY Age

Home Address City/State/Zip

Parent/Guardian Name Day Time Telephone Evening Phone Cell Phone

Parent/Guardian Name Day Time Telephone Evening Phone Cell Phone

PART II: EMERGENCY CONTACT IF PARENT/GUARDIAN CANNOT BE REACHED

Name Day Time Telephone Evening Phone

Home Address City/State/Zip Relationship to Camper

PART III: HEALTH INSURANCE INFORMATION

Name of family PHYSICIAN: Telephone: ()

Address of family PHYSICIAN: City / State / Zip

Family Medical/Hospital INSURANCE CARRIER: POLICY/GROUP NUMBER:

Do you have membership with a Health Maintenance Organization (HMO) such as Kaiser, Lifeguard, etc.? Yes No

If yes, what ID number does your child use? What is the HMO main phone number for emergencies? ()

PART IV: ALLERGIES/ILLNESSES/INJURIES

Allergic Reaction: (Check those that apply and specify nature of allergic reaction) Check here for no known allergies

Chronic or Recurring Illnesses: (Check those that apply and give appropriate dates)

Childhood Diseases: (Check those that apply and give appropriate dates)

Other Health Conditions: (Check those that apply)

List any current physical, mental or psychological health conditions requiring medical treatment, special restrictions or considerations:

List any dietary restrictions or special considerations (PLEASE NOTE: TWO SENTINELS IS NOT A NUT-FREE FACILITY!):

List any previous medical treatments, operations or serious injuries, provide dates:

PART V: MEDICATION

Over-the-counter medicines will be used to treat routine illness per Treatment Protocols. (Acetaminophen is used in place of aspirin.) Please list any over-the-counter medicines you DO NOT want your daughter to receive:

Table with columns: MEDICATION, DOSAGE, POSSIBLE SIDE EFFECTS. Includes header: Is your daughter taking any medications? NO YES. If YES, list medication, dosage, and possible side effects.

NOTE: We cannot administer medication that is not in its original container, labeled by the pharmacy with the child's name, address, dosage and frequency. Please label with name and dosage any over-the-counter drugs - antihistamines, vitamins, etc.

PART VI: IMMUNIZATION HISTORY – REQUIRED I am attaching a list of all medical immunizations with the health history form OR I attest that all immunizations for school are current (please initial)

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria, Tetanus, and Pertussis; DTP, DTaP or any combination of DTP or DTap with DT (tetanus and diphtheria)		
Tdap Booster		
Oral Polio (Sabin)* TOPV		
Injectable Polio (Salk)		
Measles, Mumps, Rubella (MMR)		
Hepatitis B		
Tuberculin test given _____ (most recent)		
Varicella		

List any condition that would limit full activity and in what way: _____

Additional comments from parents/guardians: _____

PART VII: PARENT CONSENT

This health history is correct as far as I know, and my child has permission to engage in all prescribed activities, except as noted by me and the physician. My child is in good health. I give permission for my child to receive treatment for routine medical and/or first aid needs, as outlined in the Treatment Protocols, and for the administration of prescribed medications. In the event I cannot be reached in an emergency, I give my permission for my child _____ to receive emergency medical and surgical treatment and to be hospitalized, if necessary. It is understood every effort will be made to contact me or the emergency contact noted above, before taking this action. I understand that Two Sentinels is NOT a nut-free facility. **THIS FORM IS DUE MAY 15, 2018**

*All medications being taken are listed on the front of this form.

Signature of Parent/Guardian

Date

PART VIII: RECORD OF HEALTH EXAMINATION

To be completed within 12 months of camp attendance by a **LICENSED PHYSICIAN – MD, PHYSICIAN’S ASSISTANT OR A NURSE PRACTITIONER ACTING UNDER THE SUPERVISION OF A LICENSED MD**

Dear Provider-our camp is located at an elevation of 8000 feet. Activities may include hiking with a pack, and other high-adventure activities. Please assess this camper for any pre-existing conditions, (e.g., ankle, knee, head injuries) that may affect their ability to participate in these activities.

I have examined the above applicant within the past 12 months. DATE EXAMINED _____

In my opinion, the above applicant’s condition DOES DOES NOT preclude her participation in an active program. Activities to be limited: _____

The applicant is under the care of a physician for the following conditions: _____

Current treatment (including medications): _____

Height _____ Weight _____ Blood Pressure _____

Name of Physician _____

Signature of Physician _____

Phone (____) _____

Date Signed _____

Doctor’s Office Stamp or Address