



## CAMPER HEALTH RECORD

*The following is to be filled in by a parent or guardian and reviewed by a physician.*

Name (Last, First, Initial) \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

City/Town \_\_\_\_\_ State/Zip \_\_\_\_\_

**Emergency Contact** \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

*Insurance information, please complete the following:*

Carrier \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

*Health History (check all that apply):*

Immunizations	Allergies	Chronic or Recurring Illness	Medication List
<p><i>Please include the date the series was completed of the year of the last booster.</i></p> <p>DPT _____</p> <p>MMR _____</p> <p>Polio _____</p> <p>Tetanus _____</p> <p>Chicken Pox _____</p> <p>Comments: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><input type="checkbox"/> Animals</p> <p><input type="checkbox"/> Food</p> <p><input type="checkbox"/> Hay Fever</p> <p><input type="checkbox"/> Insect Stings</p> <p><input type="checkbox"/> Medicine/Drugs</p> <p><input type="checkbox"/> Pollen</p> <p><input type="checkbox"/> Other (specify) _____</p> <p>Comments: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><input type="checkbox"/> Ear Infections</p> <p><input type="checkbox"/> Heart Defect/Disease</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Bleeding Disorders</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Musculoskeletal Disorders</p> <p><input type="checkbox"/> Nosebleeds</p> <p><input type="checkbox"/> Bed Wetting</p> <p><input type="checkbox"/> Bowel Trouble</p> <p><input type="checkbox"/> Kidney Trouble</p> <p><input type="checkbox"/> Stomach Problems</p> <p><input type="checkbox"/> Bleeding Disorders</p> <p><input type="checkbox"/> Sleep Disturbances</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Other (specify) _____</p>	<p><i>The following medications or their generic equivalent have been approved by the camp physician to be distributed by the camp nurse :</i></p> <p><input type="checkbox"/> Tylenol/Acetaminophen</p> <p><input type="checkbox"/> Advil/Ibuprofen</p> <p><input type="checkbox"/> Robitussin DM</p> <p><input type="checkbox"/> Pepto Bismol</p> <p><input type="checkbox"/> Immodium</p> <p><input type="checkbox"/> Milk of Magnesia</p> <p><input type="checkbox"/> Docusate Sodium</p> <p><input type="checkbox"/> Benadryl/Antihistamine</p> <p><input type="checkbox"/> Epi-Pen/Epi-Pen Jr. <i>(acute allergic reaction only)</i></p>

*Please describe conditions and give dates:*

Operations or serious injuries: \_\_\_\_\_

Hospitalizations: \_\_\_\_\_

Other diseases/disabilities: \_\_\_\_\_

Does your child have any special medical or dietary regimen to be followed? \_\_\_\_\_

Does your child have any activity restrictions of which the camp staff should be aware? \_\_\_\_\_

**Please attach any additional information that will be helpful and relevant to care management for your child.**



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**Medication**

Is your child currently taking any prescription medications?  Yes  No

If yes, please list medication(s) and condition(s) being treated.

MEDICATION	CONDITION
_____	_____
_____	_____
_____	_____

**Self-Administered Emergency Medication**

If your child needs to, and you want to permit your child to have readily available (carry or possess outside of the regular supervision of the camp’s health staff) and to self-administer an inhaler, an epi-pen or other emergency medication, **you and your child’s primary health care provider** must complete and sign the following consent. When your camper arrives at camp our health staff are required to evaluate the camper’s self-administration technique to ensure proper and effective use.

As the **parent or guardian** of \_\_\_\_\_, during his/her time at camp, he/she is permitted to have readily available (carry or possess outside of the regular supervision of the camp’s health staff) and self-administer as medically necessary: (Check all that apply or list other emergency self-medication device.)

- Asthma Inhaler
- Epinephrine Pen
- Other \_\_\_\_\_

I have read the State of Maine Law at <http://www.mainelegislature.org/legis/statutes/22/title22sec2496.html> and confirm that my child has the knowledge and the skills to safely have readily available and self-administer the indicated emergency medication.

\_\_\_\_\_  
 Parent or Guardian Signature Date

As the **primary healthcare provider** for \_\_\_\_\_, during his/her time at camp, he/she is permitted to have readily available (carry or possess outside of the regular supervision of the camp’s health staff) and self-administer the above medication as medically necessary.

\_\_\_\_\_  
 Primary Healthcare Provider Signature Date

**Parent/Legal Guardian Consent**

I hereby authorize River of Life Bible Camp and its camp nurse and/or approved staff to dispense over the counter medications needed including the medications listed above. I also authorize River of Life Bible Camp and its healthcare provider to dispense any prescription medication that my child takes as directed by my child’s physician. I also will ensure that any prescription medication brought to the camp by my child will be in its **original bottle, will have enough for the duration of camp plus one week left in the bottle (unless special arrangements are made in advance)**, will represent lawful use of the medication, and will not be expired or expiring during the time my child will be at camp.

By signing below, I as the Parent/Legal Guardian of \_\_\_\_\_ acknowledge that I have read and agree with the above information, and agree to comply with what is set forth herein.

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian Name (printed): \_\_\_\_\_