

# REDWOOD GLEN 2017 HEALTH FORM

## COMPREHENSIVE HEALTH HISTORY

## PHYSICIAN INFORMATION

## EMERGENCY AUTHORIZATION

(Please note: During check-in on registration day we will have a 'health screening' where we will check the Camper for lice, ask for all medications to be turned in, ask about any recent injuries, exposure to any communicable diseases, and if there have been any changes in Camper's health/usage of meds since completing this form)

Camper Name: \_\_\_\_\_  
Camper's Full Name (last, first – please enter name as entered on registration form)

Check Camp  CMAD, June 26-July 1  Middle School, June 26-July 1  Discovery, June 11-16  
Attending:  Senior High, July 16-21  Pioneer Camp, July 18-21  YMAD, July 10-15  Adventure, July 10-15

Emergency Contact Information: \_\_\_\_\_  
Camper's Emergency Contact Person      Emergency Contact Person's Relationship to Camper      (\_\_\_\_\_) \_\_\_\_\_  
Daytime Phone Number      Evening Phone Number

### Physician and Insurance Information

\_\_\_\_\_  
Doctor's Name      (\_\_\_\_\_) \_\_\_\_\_  
Doctor's Phone Number

\_\_\_\_\_  
Insurance Company      Policy Number

The Camper's Insurance is considered the primary insurance in the event of an accident or health problem while Camper is attending a camp. (Redwood Glen does; however, carry accident insurance in the event there is no family accident insurance.)

### Has the Camper had a physical in the last 24 months?

Please attach a copy of physical to this form. (Recommended, not required.)

**Please list any special limitations or restrictions** (eg. diet, glasses/contacts, retainers, hearing aids, sleepwalking, bedwetting, medical devices in use, hospitalizations or surgeries, home sickness, socialization issues, etc.) \_\_\_\_\_

**MEDICATIONS (List with instructions)** Note: All prescription medications must carry Pharmacist's label and be in original containers. All medications will be kept secure by the camp's Health Care Provider and made available as prescribed. Campers may not bring over-the-counter medications, unless they have written instructions from a licensed physician. Over-the-counter medications will be made available by the camp's Health Care Provider according to written, health-care policies and procedures.

### PARENT/GUARDIAN AUTHORIZATION

I authorize the above-named minor to fully participate in the camp they are registered for, unless restrictions are noted above. The minor may be transported in camp-designated vehicles for off-site trips and for emergency and routine medical care. I give permission to search camper belongings with the camper present when the health, well-being, or safety of the camper or others requires it.

I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to administer medications (prescription and over-the-counter); to order X-rays, routine tests, and/or treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary, related transportation for me or the above-named minor. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the minor named above. This completed form may be photocopied for trips out of camp.

\_\_\_\_\_  
Print Name      Relationship to Camper

\_\_\_\_\_  
Signature      Date      /      /

### Health History

My child has or has had the following:

#### Allergies/Dietary Restrictions:

If checked, please specify (eg. Hay Fever, Poison Oak/Ivy, Insect Stings, Pollen, Penicillin, or specific foods, drugs, or other): \_\_\_\_\_

#### Neuro/Psychological:

If checked, please specify (eg. ADD/ADHD, Epilepsy, Concussion, Convulsions, etc.): \_\_\_\_\_

#### Diseases:

If checked, please specify (eg. Chicken Pox, Measles, German Measles, Mumps, Scarlet Fever, etc.): \_\_\_\_\_

#### Other:

If checked, please specify (eg. Rheumatic Fever, Fainting, Diabetes, Asthma, AIDS, etc.): \_\_\_\_\_

### Immunization History

Please provide dates (mo/yr) of all immunizations or a copy of the Camper's records.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ DPT Series  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Polio  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ MMR (Measles/mumps/rubella)  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Tuberculin test  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Tetanus booster  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Hepatitis B  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Haemphilus Influenza (HIB)  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Other

Nurse's notes: \_\_\_\_\_