2017 CAMPER HEALTH FORM

Camper's Name_______________________________________Camp Attending___________

Medical Information

Operations or serious injuries____

Penicillin or other drug reactions____

Ever had a bee sting?_______If yes, reaction____

Food or other allergies__________________________________Special Diet______________

Medications currently being taken____

(All prescription and over the counter medications, should be in original containers clearly marked with physicians instructions, and presented to the nurse at registration.)

In case of an emergency I understand that every effort will be made to contact me. In the event that I cannot be reached, I hereby give permission to the physician selected by camp health personnel to secure proper treatment for my child including hospitalization and/or surgery. I give permission for the camp health personnel to administer non-prescription medications listed in the camp doctor's standing orders in the event of minor illness.

***Parent's Signature____Date___________**

***Immunization Record: Please complete the attached Certificate of Immunization Form (including the signature of physician, nurse, or school health authority), provided by the Colorado Department of Public Health, *or* the Statement of Exemption to Immunization Law if you are opposed to immunizations. When completing the Certificate of Immunization Form, please provide the exact date (month/day/year) that the immunization was administered. Children will not be admitted to camp without one of these two forms *fully* completed. If submitting a copy of an official immunization record, camper's name must appear on the document.**

Physician's Section

I have examined this camper and found him/her to be in satisfactory condition, free from contagious disease, and capable of active participation at 10,000 ft. for one week in a regular camping program, except as follows:_______________________________________

***Physician's Signature____Date__________**

Physician's Name____

Address____________________________________City__________State_______Zip______

Phone______________________________

Medical Insurance_________________________Policy #_________________Phone_______

Assignment of benefits (signature of family member insured)___________________________

Doctor's name and phone # (if different from above)_____________________________________

Dentist's name and phone # ____

Camp Nurse's Signature____

*Items with asterisk are required for camp admittance