2019 CAMPER HEALTH FORM

Camper's Name_____Camp Attending_____
Medical Information/Health History:
Operations or serious injuries_____
Communicable diseases, chronic illnesses_____
Penicillin or other drug reactions_____
Food or other allergies_____Special Diet_____
Instructions for applying sunscreen if desired_____
Current necessary health procedures_____
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. I authorize the application of sunscreen as needed by above instructions.

***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_____Phone_____
Address_____City_____State_____Zip_____
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_____Date_____

***Items with asterisk are required for camp admittance**