

CAMP SNOWBALL CAMPER HEALTH RECORD

CAMPER INFORMATION

Last Name _____ First Name _____ MI _____ ☐ Male ☐ Female
First time at Camp Snowball? ☐ Yes ☐ No Birth date ____/____/____ Age ____

PARENT/GUARDIAN INFORMATION (where camper resides)

Last Name _____ First Name _____ MI ____ Spouse Name _____
Address _____ Apt. # _____
City _____ State _____ Zip _____
Home Telephone _____ Business Telephone _____ Cell Phone _____

EMERGENCY INFORMATION (if Parent/Guardian cannot be reached)

Emergency Contact _____ Relationship _____ Telephone _____
Family Physician _____ Telephone _____
Health Insurance Co. _____ Policy # _____
Attach a copy of insurance card - front & back Medicaid # _____ Medicare # _____

Prescription drug policy? ☐ Yes ☐ No *If yes, attach a copy of prescription card - front & back*

NOTE: The Warwick Conference Center / Camp Warwick is not responsible for the cost of prescriptions, doctor visits, or emergency room visits during the camper's stay.

MEDICAL HISTORY

Chronic recurring illness _____ Epilepsy _____
Convulsive disorders _____ Any broken bones _____
Severe head, neck or back injury _____ Contagious diseases _____
Serious operations (list date/type) _____
Recent illness/injury _____

Please submit statement of how your child has been medically treated and with what medication.

ALLERGIES

Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Sulpha <input type="checkbox"/> Yes <input type="checkbox"/> No	Bee Sting <input type="checkbox"/> Yes <input type="checkbox"/> No
Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Penicillin <input type="checkbox"/> Yes <input type="checkbox"/> No	Suntan Lotion <input type="checkbox"/> Yes <input type="checkbox"/> No
Latex <input type="checkbox"/> Yes <input type="checkbox"/> No	Poison Ivy/Oak/Sumac <input type="checkbox"/> Yes <input type="checkbox"/> No	Other: _____

MEDICAL INFORMATION

Is this camper in general good health and able to participate in all normal camp activities? ☐ Yes ☐ No

ADD <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No	Throat problems <input type="checkbox"/> Yes <input type="checkbox"/> No
ADHD <input type="checkbox"/> Yes <input type="checkbox"/> No	As infant <input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory problems .. <input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures/Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No	Current problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetic <input type="checkbox"/> Yes <input type="checkbox"/> No
Dizzy spells <input type="checkbox"/> Yes <input type="checkbox"/> No	Chest pain/irregular heartbeat <input type="checkbox"/> Yes <input type="checkbox"/> No	Special diet <input type="checkbox"/> Yes <input type="checkbox"/> No
Motion sickness <input type="checkbox"/> Yes <input type="checkbox"/> No	Low/high blood pressure ... <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent nausea <input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic back pain <input type="checkbox"/> Yes <input type="checkbox"/> No	Ear infections <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice/Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No
Neck pain <input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty urinating <input type="checkbox"/> Yes <input type="checkbox"/> No
Homesickness <input type="checkbox"/> Yes <input type="checkbox"/> No	Vision problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney infection <input type="checkbox"/> Yes <input type="checkbox"/> No
Special needs <input type="checkbox"/> Yes <input type="checkbox"/> No	Severe menstrual cramps <input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No
Hyperactive <input type="checkbox"/> Yes <input type="checkbox"/> No		

FOR GIRLS: Has menstruated? ☐ Yes ☐ No Been told about menstruation? ☐ Yes ☐ No

Please give specific information and current status regarding any items marked "yes" above.

FOOD ALLERGIES ☐ Yes ☐ No

If "Yes", please list below or attach a separate sheet; indicate the type of allergic reaction.

What type of reaction does your child experience when ingesting these foods?

Hives ☐ Yes ☐ No

Anaphylactic Shock ☐ Yes ☐ No

GI Disturbance ☐ Yes ☐ No

What treatment is given?

None ☐ Yes ☐ No

Benadryl ☐ Yes ☐ No

Epi-pen* ☐ Yes ☐ No

Is your child able to self-administer epi-pen? ... ☐ Yes ☐ No

Other: _____

**Requires a doctor's order. Complete Medical Authorization Form in this packet.*

Camp Warwick makes every attempt to accommodate food allergies and sensitivities. However, in cases of potential life-threatening allergies families are encouraged to send their own food and snacks. We encourage you to call two weeks prior to your child attending camp to discuss specific arrangements at 845-986-1164. Ask for Arlene Tenckinck.

IMMUNIZATION RECORD

PLEASE SUBMIT AN OFFICIAL IMMUNIZATION RECORD FROM THE CAMPER'S DOCTOR'S OFFICE.

The Hepatitis B series is required by Camp Warwick unless 1) it is medically contraindicated (doctor's signature required), or b) choose not to for religious reasons (documentation by religious leader necessary).

A Tuberculosis (TB/PPD/MANTOUX) test must have been completed within two years from the start of the camp date.

MEDICATIONS

Over-The-Counter Medications: Any over-the-counter medications given to the camper must be pre-approved and signed by the camper's physician. Please complete the **USE OF OVER-THE-COUNTER MEDICATIONS** form enclosed.

Prescription Medications: All prescription medication must be in the original container, labeled with the camper's name and written instructions signed by your physician. Please complete the **PARENTAL & PHYSICIAN'S AUTHORIZATION FOR ADMINISTERING PRESCRIPTION MEDICATIONS** form.

CONSENT RELEASE FOR CAMP SNOWBALL

In signing this release, I certify that the information on this form is correct. In case of a medical emergency, I authorize the release of medical records and understand that every effort will be made to contact the parent/guardian. **In the event that the parent/guardian cannot be reached, permission is hereby given to the physician selected by the Warwick Conference Center to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my son/daughter/ward, as named herein.** I understand that I am responsible for the cost of prescriptions, doctor visits and/or emergency room visits during my son/daughter/ward's stay at Camp Snowball. I authorize the Camp Snowball Health Director to supervise the self-medication of prescription and over-the-counter medicines by my son/daughter/ward. I give permission for my son/daughter/ward to be transported in the Warwick Conference Center vehicles or other designated vehicles to and from public transportation. I give permission for my son/daughter/ward to be transported in the Warwick Conference Center vehicles as necessary for approved off-site camp activities. I authorize the use of photographs and videos of my son/daughter/ward in camp publicity.

PARENT/GUARDIAN SIGNATURE

DATE

OFFICE USE ONLY

NURSE'S NOTES:
