

Camper's Name \_\_\_\_\_

**Health Evaluation**

**\*REQUIRED - PLEASE ATTACH A CURRENT RECORD OF IMMUNIZATIONS\***

Name of Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Camper Height \_\_\_\_\_ Weight \_\_\_\_\_ Operations / Serious Injuries (dates) \_\_\_\_\_

Please check all that apply:

<u>Is your child subject to:</u>	<u>Allergies:</u>	<u>Does or has s/he had:</u>	<u>Other Concerns:</u>
Colds _____	Insect Stings _____	Seizure disorder _____	Eyewear _____
Ear Infection _____	*Type _____	Diabetes _____	Headaches _____
Convulsions _____	Poison Ivy _____	Heart Condition _____	Dental Needs _____
Neck/Back Problems _____	Penicillin _____	Bleeding disorder _____	ADD/ADHD _____
Fainting Spells _____	Medications _____	Asthma _____	Skin Problems _____
Sleep Walking _____	Food _____	Eating disorders _____	Balance issues _____
Nose Bleeds _____	Latex _____	Psychological or Behavioral Disorders _____	Learning Disabilities _____

If any of the above is applicable, please explain (on a separate paper if necessary) \_\_\_\_\_

This applicant is under the care of a physician for the following condition(s) \_\_\_\_\_

Additional health information \_\_\_\_\_

**Recommendations and Restrictions While at Camp**

Suggestions on health-related information for camp personnel \_\_\_\_\_

Activities to be encouraged or limited \_\_\_\_\_

Dietary restrictions (if applicable) \_\_\_\_\_

Any treatment to be continued at camp \_\_\_\_\_

Additional health information, including any relevant at-home treatment (If necessary, please attach a separate sheet) \_\_\_\_\_

**Medication Permission Form** (\*\* required if campers are to receive any over-the-counter or prescription medication at camp\*\*)

If a camper is expected to need medication during the camp session (prescription or over-the-counter), the child's doctor **must** give written permission to the counseling staff to dispense the medication. In order for a member of the staff to dispense medication brought with the camper, the medication must be in the original bottle with the original written instructions from the doctor. The counseling staff will be responsible for supervising the camper's self-administration of the medication according to the given instructions.

If the camper comes to camp with medication without meeting the above conditions, the camper will be unable to participate in the camp program until those conditions are met. In addition, if the conditions above are not met and/or the camp has not been made aware of the camper's medication, the camp bears no responsibility for any problems that may arise.

**ANY medication to be dispensed at camp (OTC or prescription): Please list and have physician sign below. Medication brought to camp without parental and physician permission, and not accompanied with the original bottle and written instructions, will not be dispensed. Use additional sheet if necessary.**

<u>Name (generic/brand)</u>	<u>Dosage</u>	<u>Reason for taking/comments</u>
_____	_____	_____
_____	_____	_____

*Health Care Provider: Please initialize the medications you authorize for use (if needed) by this individual.*

Aspirin \_\_\_\_\_ Acetaminophen \_\_\_\_\_ Antihistamine \_\_\_\_\_ Ibuprofen \_\_\_\_\_ Anti-diarrhea \_\_\_\_\_ Topical treatments \_\_\_\_\_

Other OTC medications: \_\_\_\_\_

I authorize Genesee Valley personnel to dispense medication to this camper under the conditions stated above.

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

I give my permission for Genesee Valley personnel to dispense medication to my child under the conditions stated above.

**ONLY SIGN IF YOU HAVE ALREADY RECEIVED A PHYSICIAN'S SIGNED PERMISSION.**

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