 Camper Last Name: _____ **First Name:** _____

PLEASE PRINT SINGLE-SIDED; DO NOT STAPLE PAGES

Табір: □ **пташата** □ **новак** □ **новачка** □ **юнак** □ **юначка**

Primitive Camping Health & Release Form

THIS SECTION TO BE FILLED OUT BY PARENT(S)

Camper Name: _____

Birthdate ____/____/____ Age____ Gender____

Birthplace _____

Religion _____

Parent/Guardian _____

Address _____

City/State/Zip _____

Home Phone _____

Cell Phone (Mother) _____

Cell Phone (Father) _____

Emergency Contact

Name: _____

Relationship: _____

Address: _____

City/State/Zip: _____

Home Phone: _____

Cell Phone: _____

Attach a copy of the front of your insurance card here.
DO NOT STAPLE. TAPE or GLUE or provide on separate sheet

If you do not have insurance, note the following and sign:

☐ ☐ ☐

Credit Card type Visa MasterCard _____

Credit Card Number: _____

Expiration: _____

Signature: _____

Attach a copy of the back of your insurance card here.
DO NOT STAPLE. TAPE or GLUE or provide on separate sheet

This health history below and on the following 2 pages is correct to the best of my knowledge, and the camper herein described has permission to engage in all prescribed camp activities, except as restricted by my or the examining physician's notation on this form, with the understanding that the camper is engaged in primitive camping. Understanding that every reasonable effort will be made to reach me, I hereby give permission to the camp administrator or his/her designee to secure treatment for the camper that is deemed needed or appropriate, at a medical facility of his/her choosing, and the physician so chosen to provide such care, to include, if deemed necessary, hospitalization, injection(s), administration of anesthesia, or surgery. Responsibility for payment of any such services remains my own, regardless of insurance status. I agree to notify camp authorities if the camper is exposed to communicable diseases in the 3 weeks prior to the beginning of camp and to any significant changes in health status prior to camp onset.

Signature of Parent/Guardian _____ **Date**_____

I give permission to administer over-the-counter medications to my child if needed; these may include: acetaminophen, ibuprofen, hydrocortisone topical, triple antibiotic cream/topical.

Signature of Parent/Guardian _____ **Date**_____

THIS SECTION TO BE FILLED OUT BY EXAMINING PHYSICIAN

Allergies to Foods

Food	Type of Reaction (ex: life threating anaphylaxis, hives, vomiting, etc)

Allergies to Medications

Medication	Type of Reaction

 Camper Last Name: _____ **First Name:** _____

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Табір: □ **пташата** □ **новак** □ **новачка** □ **юнак** □ **юначка**

Other Allergies and Intolerances

☐ bee sting ☐ poison ivy/oak/sumac ☐ hay fever ☐ latex ☐ Other _____

_____

_____

Table of Medications to Take at Camp (list prescription and over-the counter medications)

Drug Name	Reason for Taking	Form (tablets, inhaler, etc.)	Dose	Frequency	Can Camper Self Administer

Please list or describe any Medical Conditions (including behavioral/psychological):

_____

_____

_____

_____

Restrictions and Limitations

Describe any and all other potential restrictions on activities, keeping in mind that 11-18 year olds especially will be in primitive facilities ¾ mi. from main buildings and have a planned 3-day hike away from ready medical access. Comment on the child's independence and ability in: 1) abiding by dietary restrictions; performing ADLs independently including hygiene; calorie counting, monitoring serum glucose, calculating and administering own insulin injection; developmental/behavioral/psychiatric issues; enuresis; ability to participate in sports, swimming, backpacking at age-appropriate level.

_____

_____

_____

 Camper Last Name: _____ **First Name:** _____

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Табір: □ **пташата** □ **новак** □ **новачка** □ **юнак** □ **юначка**

Immunizations

Please attach vaccine record or record of dates of vaccines given below:

Tetanus(DTaP/DtaP/Td/TDaP): _____ MMR: _____ Pneumococcal (PCV/Prevnar):: _____

Hib: _____ Hepatitis B: _____ Varicella (Chicken Pox): _____

Polio: _____ Hepatitis A: _____ Other (typhoid , etc): _____

Meningococcal: _____

Date of Last Tetanus Vaccine:	

Past Medical History

List ongoing or recurrent medical conditions for which the camper is receiving medical care, prior surgeries, major infectious diseases, etc..

☐ **tuberculosis** ☐ **rheumatic fever** ☐ **chicken pox** ☐ **measles** ☐ **German measles** ☐ **mumps**

☐ **kidney disease** ☐ **heart disease** ☐ **hypertension** ☐ **diabetes** ☐ **freq. otitis media** ☐ **asthma**

☐ **fainting spells** ☐ **seizures** ☐ **bleeding/clotting disorder** ☐ **mononucleosis** ☐ **abnl. menses**

☐ **noct-enuresis** ☐ **somnambulism** ☐ **behavioral issues (explain below)**

_____

_____

_____

Physical Examination

Height_____ **Weight**_____ **kg. lb.** **Does camper wear glasses or contacts?** _____

B.P._____ **Pulse**_____

	NL	Abnl. / Comments
Skin	☐	_____
Head	☐	_____
Eyes	☐	_____
Ears	☐	_____
Nose	☐	_____
Throat	☐	_____
Lungs	☐	_____
Heart	☐	_____
Abdomen/GI	☐	_____
Extremities	☐	_____
Genitourinary	☐	_____
Musculoskeletal	☐	_____
Neurologic	☐	_____

Comments, Other Positives, or Significant Negatives

_____

_____

Family Physician

Name, Degree _____

Address _____

City/State/Zip _____

Phone _____

Examining Physician

Name, Degree _____

Address _____

City/State/Zip _____

Phone _____

Physician Signature

License# _____

State _____

Date Examined _____

Signature _____