

CAMPER'S NAME _____ DATE OF BIRTH _____ AGE AT CAMP _____ MALE /FEMALE

SESSION CAMPER ATTENDING CAMP (circle one) Full Summer July August Get Your Feet Wet

Camp Eagle Hill Medical Form – PART A (PARENT FORM)

CAMPER'S HOME ADDRESS _____
Street City State Zip

PARENT or GUARDIAN _____

HOME ADDRESS _____ HOME PHONE () _____
Street City State Zip

WORK ADDRESS _____ WORK PHONE () _____
Street City State Zip

CELL PHONE () _____

SECOND PARENT or GUARDIAN _____

HOME ADDRESS _____ HOME PHONE () _____
Street City State Zip

WORK ADDRESS _____ WORK PHONE () _____
Street City State Zip

CELL PHONE () _____

EMERGENCY CONTACT (IF PARENTS or GUARDIANS UNAVAILABLE) _____

Relationship to Camper _____ HOME PHONE () _____ WORK PHONE () _____

Home Address _____ CELL PHONE () _____
Street City State or Country Zip

MEDICAL CONSENT FORM (to be signed by parent or guardian)

This health history is correct and complete as far as I know. The described on this form has permission to engage in all Camp activities except as noted.

I hereby give permission to the Camp Director or medical personnel selected by the Camp Director, to provide, seek, and consent to routine health care, administration of prescribed medications and non-prescription medications (as noted on this form), dental work where needed, and any treatment for my child as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission to the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* for the camper named on this form. Further, it is my intention to have the appropriate representatives of the camp be treated

as "personal representatives" for disclosing protected camper health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree to the disclosure to camp representatives of the protected health information of the camper described herein as necessary: (i) to provide relevant information to the camp representatives related to camper's ability to participate in camp activities; and (ii) to provide relevant information to the camp representatives to keep me informed of my child's health status.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the camper named on this form. This completed form may be photocopied for use on trips out of camp.

Date _____ Parent's/Guardian's Signature _____

Parent's/Guardian's Printed Name _____

A Copy of a Medical Insurance Card and Dental Insurance Card must be attached to this form. The Camp will be using its own policy for camper visits to the local pediatrician's office for new illnesses, conditions or ailments. We will be using family insurance coverage for pre-existing conditions or should we visit a dental office, specialists office or local hospital.
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Camp Eagle Hill Medical Form – PART B (PHYSICIAN FORM)

MEDICAL EXAMINATION (to be filled in by physician)

CAMPER'S NAME _____

Height _____ Weight _____ BP _____ Hgb. _____ Urinalysis _____

1. This child is under the care of a physician for the following conditions:

2. Please state any physical disability that this child has: _____

3. Has this child had any surgery? If yes, for what, and when?

4. Has this child ever had any serious illnesses? If yes, what type, and when? _____

5. Has this child had any recurring illnesses?

6. Are there to be any restrictions for this child while in camp? _____

7. Are swimming and diving permitted? _____

8. Is strenuous activity permitted? _____

9. Any additional health information or special instructions for this child? _____

10. Any treatment to be continued at camp? _____

11. Any medically prescribed meal plan or dietary concerns? _____

12. Any special instructions for the camp? _____

I have examined _____ and have reviewed his/her health history. This health history is correct so far as I know. It is my opinion that he/she is physically able to engage in all activities, except as noted above.

Date of Form Completion _____

Examining Physician's Signature M.D

MEDICATIONS TO BE TAKEN AT CAMP (to be filled in by physician)

Please list all medications, including all over-the-counter or non-prescription drugs, taken routinely or as needed (PRN). Please send along enough medication for your child's session of camp. In addition, please keep any medication in original packaging so that the original bottle can identify the prescribing physician. (in the case of prescription medication) This will allow us to see the name of the medication, the dosage to be taken, and the frequency of administration.

MEDICATION #1: _____ **Dosage** _____ **Specific Times Taken Each Day** _____

Reason For Taking _____

MEDICATION #2: _____ **Dosage** _____ **Specific Times Taken Each Day** _____

Reason For Taking _____

MEDICATION #3: _____ **Dosage** _____ **Specific Times Taken Each Day** _____

Reason For Taking _____

