ABCRM Front Range Camping
at Quaker Ridge Camp
July 13-19, 2014

Health and Examination Form
for Children and Youth attending Camp

Mail this form to the address below by **June 30, 2014**:
ABC of the Rocky Mountains
Front Range Camping
9085 E. Mineral Circle Suite 170
Centennial, CO 80112

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Parents/guardians of minors must fill out this form. Update required annually. Health exam (page 4) must be completed by approved licensed medical personnel at least every two years. ***If you plan to use this same doctor's permission next summer, please keep a copy for your records.*** **PLEASE PRINT LEGIBLY.**

CAMPER

Last Name: ______________________________ First Name: ______________________________ MI: _____

Home Address: ____

City: ______________________________ State: ____________ Zip: ______________

Date of Birth: ______ / ______ / ______ Gender: ☐ Male ☐ Female

Parent's Name: ______________________________ Home Phone: ( ) ______________

Cell Phone: ( ) ______________________ Work Phone: ( ) ______________________

EMERGENCY CONTACT (*in case parent cannot be reached*):

Last Name: ______________________________ First Name: ______________________________

Home Address: ____

City: ______________________________ State: ____________ Zip: ______________

Relationship to Camper: ______________________ Home Phone: ( ) ______________

Cell Phone: ( ) ______________________ Work Phone: ( ) ______________________

HEALTH INSURANCE INFORMATION

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

Insured Member's Name: ____

Carrier's Name: ______________________________ Plan Name: ______________________

Phone: ( ) ____

Group #: ______________________________ Member ID #: ______________________________

HEALTH HISTORY

The following information must be filled in by the parent or guardian. The intent of this information is to provide camp personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participants arrival in camp. Provide complete information so that the camp can be aware of your needs.

Allergies: For Example: Hay Fever, Poison Ivy, Insect Stings, Penicillin, Other Drugs, Peanuts, Food or Animals:

Allergy — list below	Detailed Description	Medication Required

Medications: ☐ Yes, this person takes medications * ☐ No, this person does not take medications

* ***If yes, please complete the Medications Form*** (page 3)

GENERAL QUESTIONS (please explain "yes" answers below)

Has/does the participant:

	Yes	No
Had any recent injury, illness or infectious disease?	☐	☐
Have a chronic or recurring illness/condition?	☐	☐
Ever been hospitalized?	☐	☐
Ever had surgery?	☐	☐
Have frequent headaches?	☐	☐
Ever had a head injury?	☐	☐
Ever been knocked unconscious?	☐	☐
Wear glasses, contacts or protective eye wear?	☐	☐
Ever had frequent ear infections?	☐	☐
Ever passed out during exercise?	☐	☐
Ever been dizzy during or after exercise?	☐	☐
Ever had chest pain during or after exercise?	☐	☐
Ever had seizures?	☐	☐
Ever had high blood pressure?	☐	☐
Ever been diagnosed with a heart murmur?	☐	☐
Ever had back problems?	☐	☐
Ever had problems with joints?	☐	☐
Have an orthodontic appliance being brought to camp?	☐	☐
Have any skin problems (e.g., itching, rash, acne)?	☐	☐
Have Diabetes?	☐	☐
Have asthma?	☐	☐
Had mononucleosis in the past 12 months?	☐	☐
Had problems with diarrhea or constipation?	☐	☐
Have problems with sleepwalking?	☐	☐
If female, have an abnormal menstrual history?	☐	☐
Have a history of bed-wetting?	☐	☐
Ever had an eating disorder?	☐	☐
Ever had emotional difficulties for which professional help was sought?	☐	☐

Please explain any "yes" answers. Use additional paper if necessary.

____

____

____

____

☐ ***IMMUNIZATION: a copy of the participants immunization record MUST be attached/included with this form.***

Physician's Name: ______________________________ Phone: ( ) ____________________

Dentist's Name ______________________________ Phone: ( ) ____________________

This health history is correct and complete as far as I know. The person herein described has my express consent to participate in all camp activities, including transportation by bus or mini-bus, except as noted. By giving this consent, I expressly acknowledge that I have been made aware that my child may be exposed to the risks of nature and of the elements over which neither the American Baptist Churches of the Rocky Mountains (ABCRM)/Camp nor its employees have control. Having been informed of such risks, I specifically agree that my child may participate in the program. This completed form may be photocopied for trips out of camp.

I hereby give permission to the physician selected by the camp director to order X-rays, routine tests, treatment, and emergency transportation for the health of my child. I hereby give permission to release the results of any of the aforementioned tests or treatment to the Camp and ABCRM. In the event I cannot be reached in an emergency, I hereby give permission to the physician or medical facility selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named on this form.

I accept responsibility for medical/surgical treatment charges which may be incurred on my child's behalf. I accept responsibility for the cost of any prescriptions and/or related expenses for my child's care and understand I will be billed by the ABCRM office.

Signature of Parent or Guardian: ____

Printed Name: ______________________________ Date: ____________________

MEDICATIONS FORM

Please list all current medications your child is currently taking. ***All medications must be in their original packaging that lists the prescribing physician an instructions.***

1. Name of Medication: ____________________ Dosage: ____________________

   Specific times to be given: ____________________

   Instructions: ____________________

   ____

   Physician: ____________________

   Is camper bringing this medication to camp? ☐ Yes ☐ No

2. Name of Medication: ____________________ Dosage: ____________________

   Specific times to be given: ____________________

   Instructions: ____________________

   ____

   Physician: ____________________

   Is camper bringing this medication to camp? ☐ Yes ☐ No

3. Name of Medication: ____________________ Dosage: ____________________

   Specific times to be given: ____________________

   Instructions: ____________________

   ____

   Physician: ____________________

   Is camper bringing this medication to camp? ☐ Yes ☐ No

4. Name of Medication: ____________________ Dosage: ____________________

   Specific times to be given: ____________________

   Instructions: ____________________

   ____

   Physician: ____________________

   Is camper bringing this medication to camp? ☐ Yes ☐ No

Please use additional paper if necessary.

HEALTH CARE RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL

Camper's Name: ____

TO BE FILLED OUT BY A LICENSED PHYSICIAN FOR ALL CHILDREN AND YOUTH CAMPERS. This examination should be performed within 24 months of the date camper will **leave** camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

Code: V — *Satisfactory* X — *Not Satisfactory (explain)* O — *Not examined*

BP ______________ Weight ______________ Height ______________

Eyes ____________
Glasses ____________
Ears ____________
Nose ____________
Throat ____________
Heart ____________
Genitalia ____________
Lungs ____________
Abdomen ____________

Hernia ____________
Extremities ____________
Including: ____________
Shoulder ____________
Knees ____________
Ankles ____________
Feet ____________
Posture (Spine) ____________
Skin ____________

Allergy: (please specify)
____
____

General Appraisal:
____
____

FOR FEMALES

Has this person menstruated? ______________ If not, has she been told about it? ______________

If so, is her menstrual history normal? ______________ Special considerations: ______________

____

The camper is under the care of a physician for the following conditions: ______________________

____

Does camper have epilepsy? ☐ Yes ☐ No Does camper have diabetes? ☐ Yes ☐ No

RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP:

Medically prescribed meal plan or dietary restrictions: ______________________

Any restrictions for: Swimming/Boating ______________________

Strenuous Activity ______________________

Other ______________________

Is the camper currently taking any prescribed medications? ☐ Yes, complete Medications Form (page 3) ☐ No

PHYSICIAN'S SIGNATURE REQUIRED

On the basis of your knowledge of the applicant, the applicant's medical history, the present physical examination of this applicant and your knowledge of the activities in which they will participate, do you feel this individual is able to participate in camp activities? ☐ Yes ☐ No

Physician' Printed Name: ______________________

Signature: ______________________ Date: ______________

Address: ______________________ Phone: ( ) ______________

____

PARENTS: If you plan to use this same doctor's permission next summer, please keep a copy for your records.