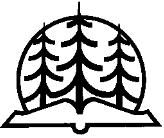

New England Frontier Camp Camper Medical Form

ovell, ME 04051 Tel.:207-925-6735 Fax: 207-925-1141

Week of:
Program:

Personal Information

Name ____________________ Birth date ________ Age ____

Address ____________________ Social Security #__________

City, State, Zip Code____________________

Custodial parent(s)/guardian ____________________ Phone __________

Home Address (if different from above)____________________

Business Address ____________________ Phone __________

Second parent or guardian (if different from above) ____________________

Home____________________ Phone__________

Business Address____________________ Phone __________

Emergency Contact

If not available in an emergency, please notify:__________ Relationship__________

Address ____________________ Phone __________

If you plan to be on vacation or away from home during your son's time at camp, where can you be reached?

Address ____________________ Phone __________

Family Medical Information

Name of family physician____________________ Phone __________

Name of family dentist / orthodontist ____________________ Phone __________

Insurance Information

Insurance plan name ____________________ Subscriber ID # __________

Insurance Plan Phone # ____________________

Subscriber____________________ Relationship to camper ________

Prescription Information (Please complete if different from above.)

Insurance plan name ____________________ Subscriber ID # __________

Insurance Plan Phone # ____________________

Subscriber____________________ Relationship to camper ________

☐ Check here if pre-authorization is required for non-emergency medical care. (Every effort will be made to notify parents prior to any medical treatment, however be aware that pre-authorization is the responsibility of the subscriber.

Permission to Treat

I hereby give my permission for my child named above to attend camp and participate in camp activities.

I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to administer medications; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child named above. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child named above.

This form may be photocopied for use out of camp

____

Signature of custodial parent or guardian Date

Don't forget to fill out the other side!

Health History

The following information must be filled out by the parent/guardian. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Provide complete information so we can be aware of your needs. **Keep a copy of this form for your records**. Check all that apply and comment below.

ف Head injury, concussion ف Dizziness, Fainting ف Seizures ف Frequent ear infections ف Glasses / contact lenses ف Orthodontic appliance ف Skin disorders (itching, rash) ف Hives ف Heart defect/disease ف Asthma	ف Bleeding/clotting disorders ف Mononucleosis ف HIV positive ف Diabetes ف Sleepwalking ف ADD/ADHD ف Depression, Psych Disorder ف Back problems ف Joint problems (knees, ankles) ف Bedwetting	Known Allergies ف Bee / insect stings ف Medications ف Food / Nuts ف Poison ivy / environmental ف Other Describe reaction and management to the reaction:________________________ ______________________________

Please comment on any of the above

____

____

Immunization History	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DPT*	______	______	______	______	______	______
TD* (tetanus/diphtheria)	______	______	______	______	______	______
Tetanus*	______	______	______	______	______	______
Polio	______	______	______	______	______	
MMR	______	______				
Hepatitis-A	______	______				
Hepatitis-B (HBV}	______	______	______			
Varicella (chicken pox)	______					

*Tetanus must be within 10 years of camp

The participant has had...
- ف Measles
- ف Chicken pox
- ف German Measles
- ف Mumps

Hepatitis ف A ف B

TB Mantoux or PPD
Date of last test ____________
ف Positive ف Negative

Medications ف This person takes NO medications on a routine basis ف This person takes medications as listed below

Please list all prescription and non-prescription medications your son will be bringing to camp. List only those medications which he will be taking at camp time. **Prescription medications** must be **IN THE ORIGINAL CONTAINER** with **doctor's instructions clearly indicated.** All medications will be stored in the camp Health Center and administered by the camp health care personnel.

Medication (e.g. Penicillin)	Dosage / Frequency (e.g. 250mg three times daily)	Reason for taking (e.g. Strep Throat)	For camp health care staff use

Health Care Recommendations by Licensed Medical Personnel
A health examination by licensed medical personnel is not required, but is *highly encouraged* at least every two years.

Date of last examination ________________

BP__________ Weight _______ Height ______

In my opinion, the above applicant ف is ف is not able to participate in an active camp program.

The applicant is under the care of a physician for the following condition(s):__________________

____

Current treatment at the time of this report:

____

____

Recommendations and restrictions at camp

Treatment to be continued at camp: ______________________________

____

Medications to be administered at camp (name, dosage, frequency):

____

Known allergies: ____

____

Additional information for health care staff of the camp:

____

Signature of Licensed Medical Personnel ______________________________________

Printed ______________________________________ Title ____________________

Date of form completion Phone

For camp health care staff use

Screened by ______________________________ Date __________ Time __________ Updates / additions ف yes ف none

Screened by ______________________________ Date __________ Time __________ Updates / additions ف yes ف none

Screened by ____