

Health History /Emergency Treatment Form

Week of Attendance _____

Point Reyes Summer Camp 2010

Postmark on or before April 1, 2010 (earlier submissions are appreciated)

Mail to: Health Form, Point Reyes Summer Camp

PRNSA, 1 Bear Valley Road, Bldg. 70

Point Reyes Station, CA 94956

The information on this form is not part of the camper acceptance process. It is gathered to assist us in identifying appropriate care. Any changes to this form must be provided to the camp administrative staff upon participant's arrival at camp. Please provide all requested information to assist us in being adequately prepared to care for your child.

Camper name _____ Birth date ___/___/___ Sex ___ Age at camp ___

Street Address _____ Home Phone () _____

City, State, Zip _____

School _____ Grade in Fall 2010 _____

Whom to Notify in Case of Emergency

1. Custodial Parent or Guardian _____

Day phone () _____ Night phone () _____ Cell () _____

2. Second Parent or Guardian _____

Day phone () _____ Night phone () _____ Cell () _____

3. Local Relative or Close Family Friend _____

Day phone () _____ Night phone () _____ Cell () _____

4. Family Friend or Neighbor _____

Day phone () _____ Night phone () _____ Cell () _____

Insurance Information

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

Insurance Carrier or Plan Name _____ Group # _____

Family Doctor _____ Phone () _____

Required Parent/Guardian Authorizations This health history is correct and complete as far as I know and the person herein described has permission to engage in all camp activities except as noted.

I, the undersigned parent/legal guardian of the above, a minor, do hereby give permission to the medical personnel selected by the Camp Director or designee to order x-rays, routine tests, treatment; to release any records necessary for treatment, referral, billing, or insurance purposes; and to provide or arrange necessary related transportation for my child. In the event that I cannot be reached in an emergency, I hereby give permission to the health care providers selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

(REQUIRED) Signature of Parent/Guardian _____ **Date** _____

Printed Name _____

**If for religious reason, you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.*

(Optional) I authorize the administrators at Point Reyes Summer Camp to administer **Tylenol (or children's Tylenol, if appropriate)** in the appropriate dosage for my child's age and weight if they deem necessary.

Signature of Parent/Guardian _____ Date _____

Printed Name _____

Cabin Assignment

If possible, I would prefer my child be placed in the same cabin with _____

We permit one request per child. While we can not guarantee the placement, we will attempt to arrange it.

Comfort Level at Camp

My child has been overnight away from home _____ nights. Please describe (with friends or relatives, overnight camp, school trip, etc) _____

My child has a tendency to experience homesickness yes no not sure

MEDICATIONS Please list all medications (including over-the-counter, prescription drugs, vitamins, etc) taken routinely. If your child has a medical condition or takes any kind of medication, we will contact you prior to camp.

My child takes **NO** regular medication.

My child takes medication(s) as follows:

Med #1 _____ Dosage _____ Specific time(s) taken each day _____

Reason _____

Med #2 _____ Dosage _____ Specific time(s) taken each day _____

Reason _____

Med #3 _____ Dosage _____ Specific time(s) taken each day _____

Reason _____

List medications taken during the school year that you child may not take during the summer:

Health History (Please circle yes or no; provide comments regarding management of condition where applicable)

Yes No 1. **Severe** Bee Sting Allergies, we require that each child bring 2 sets of beesting kits (Epipen and Benadryl)

Date and severity of last reaction _____

***If your child has minor reactions to bee stings, please bring Benadryl.*

Yes No 2. Asthma (Include date of last attack)

Trigger(s) and date of last attack _____

Yes No 3. Heart Condition Comments _____

Yes No 4. Diabetes Comments: _____

Yes No 5. Epilepsy (Include date of last seizure)

Date and severity of last episode _____

Yes No 6. Frequent **Severe** Headaches or Fainting

Date and severity of last episode _____

Yes No 7. Difficulties with any of the following: Mobility Speech Hearing Vision Bedwetting

Details _____

ALLERGIES List all known.

Medication(s) Describe reaction and management of the reaction.

Food(s)

Other (include insect stings, plants, pollen, chemicals, etc)

Date of child's last tetanus shot _____ I don't know

Please provide any additional information about your child's overall physical and emotional well-being and/or behavioral tendencies about which the camp administration should be aware.

Dietary Restrictions

Does not eat Red Meat Pork Poultry Seafood Eggs Dairy products Other (List _____

Activity Limitations

List and explain any activity restriction(s) your child requires _____

My child will be bringing inhalers. Yes No

My child will be bringing bee sting kits (Anakit or Epipen Jr or similar). Yes No

Jr. Adventure & Adventure Campers Only (12-16 yr olds) If possible, my child would like to borrow the following equipment: sleeping bag backpack sleeping pad other _____

Please Note: We have limited equipment availability and give priority to our scholarship recipients.