

Camp Downer Health Statement and Parent/Guardian Approval Form

To be completed by parent or guardian. Please PRINT and Please use blue or black ink only.

DO NOT MAIL THIS FORM...BRING TO REGISTRATION PLEASE!

(For confidential use by camp staff and health care professionals as needed.)

Camper Last Name: _____ Camper First Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth (Month, Day, Year): _____ Age: _____ Sex: Male Female

1. Check all medical conditions camper has:

Comments on medical conditions:

- Asthma
- Frequent Earaches
- Heart Disease
- Rheumatic Fever
- Emotional/behavioral
- Epilepsy
- Diabetes
- Physical challenges, injuries, orthopedic
- Serious illness in past year
- Hearing Problems

Will the camper wear a hearing aid at Camp? Yes No

Vision Problems

Will the camper wear glasses in Camp? Yes No

Will the camper wear contacts in Camp? Yes No

Dietary Restrictions - If checked, please complete Dietary Restrictions Form **(Attachment A)**.

Pre-Existing Injury - If checked, Physician must complete Pre-Existing Injury Form **(Attachment B)**.

Allergies (List All): _____

2. Has the camper:

a. Had loss of eye, lung, kidney, ovary or testes? Yes No Specify: _____

b. Had loss of vision or hearing? Yes No Specify: _____

c. Had loss of consciousness with head injury? Yes No Specify: _____

Date: _____ Activity Restrictions: _____

d. Any serious illness in the last year? Yes No Specify: _____

e. Started menstruating? Yes No

3. Does the camper...

a. Take prescribed medication of any kind? Yes No

b. Take any over the counter medication? Yes No

c. If a. or b. is yes, will camper have to take it during camp? Yes No

If YES, you must attach the enclosed Camper Medication Dispensing Form (Attachment C) completed and signed by the camper physician.

4. Does the camper have a known sensitivity to any medication such as penicillin, aspirin, etc?

Yes No If yes, what medications? _____

5. Has camper been exposed to any contagious disease within the last three weeks such as strep throat, measles, mumps, lice, etc?

Yes No If yes, which contagious diseases? _____

7. Please indicate last medical exam information:

Name of examining physician/clinic, health center or school: _____

Date of Exam: Month: _____ Year _____

EVERY CAMPER MUST SHOW PROOF OF HAVING HAD A PHYSICAL EXAMINATION WITHIN THE TWO YEARS PRIOR TO ATTENDING CAMP. Please attach a copy of a physical examination form to this form. If this camper has not had a physical examination within the last two years, the attached Comprehensive Physical Form (Attachment D) (or a signed statement by the examining family physician, clinic, health center, or school that it is safe for the camper to participate in camp) must be completed and must accompany this statement.

8. Immunizations:

All campers must either:

A) attach a printed report of immunizations from their health care provider, or

B) complete the attached Immunization Form (Attachment E) or

C) complete and attach a Vermont Department Of Health Medical or Religious Exemption Form.

Camp Downer does not accept Philosophical Exemptions.

9. Please list any activities in which you do not want your camper to participate:

10. Camper's Physician Information

Name: _____ (Last Name, First Name, Middle Initial)

Street Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

11. Health Insurance Information (To cover emergency treatment):

Camper Social Security Number: _____ - _____ - _____ (Requested by emergency providers.)

Insurance Company Name: _____

Insurance Policy Number: _____

Insurance Coverage via Parent/Guardian Policy? Yes No

Name of Employer for the Insured Policy Holder: _____

Name of Policy Holder: _____

12. Signature Acknowledgement:

To the best of my knowledge, my son/daughter/camper is in good health and can participate in this activity. I have indicated above any reasonable accommodations needed to meet my son/daughter's mobility, vision, hearing or other needs, as well as any health problems or medical conditions that may interfere with his/her participation.

By signing below, I hereby give permission for the listed camper to participate in Camp Downer's camping program and I also give permission to the group leader(s) to obtain necessary medical treatment for my son/daughter/camper in the event I cannot be reached in an emergency. I understand that the camp shall not be liable for expenses associated with any medical treatment for injuries my son/daughter/camper may sustain by virtue of his/her participation in the program.

Sign Here

Parent/Guardian Signature: _____ Date: _____

Printed Name of Parent/Guardian: _____

Relationship to Camper: _____

Parent/Guardian Home Phone(s): _____

Parent/Guardian Work Phone(s): _____

Parent/Guardian Cell Phone(s): _____

Parent/Guardian Home Address: _____

If you can not be reached, please give (in order) the name and phone number of parent/guardian(s) we should contact:

Name: _____ Relationship: _____ Phone _____

Name: _____ Relationship: _____ Phone _____

ATTACHMENT A
Dietary Restrictions Form

To be completed by parent or guardian. Please PRINT and Please use blue or black ink only.

Camper Last Name: _____ Camper First Name: _____

Date of Birth (Month, Day, Year): _____

The dates that your child will be attending camp: _____

Dietary Restrictions:

My child has NO dietary restrictions
(If your child has no dietary restrictions do NOT make a photocopy of this form and do NOT mail it to camp.)

OR

My child HAS dietary restrictions
Please complete this form and make a photocopy. Please bring original to registration. Please mail the photocopy prior to June 1st to: Camp Downer, 70 S. Winooksi Ave. #196, Burlington, VT 05401. After June 14th mail to: Camp Downer, 1535 Downer Rd., Sharon, VT 05065. The advance copy will allow our kitchen to be able to provide more balanced alternatives as needed. (For confidential use by camp staff and health care professionals as needed.)

Check any that apply to this camper:

- Does not eat red meat
- Does not eat poultry
- Does not eat pork
- Does not eat seafood
- Does not eat eggs
- Does not eat dairy products
- Does not eat gluten
- Does not eat nuts. Camp Downer is NOT a nut free camp. This includes both peanuts and tree nuts.
- Other-Please describe:

Sign Here  Parent/Guardian Signature: _____ Date: _____

ATTACHMENT B
Camper Pre-Existing Injury Form

To be completed by parent or guardian. Please PRINT and Please use blue or black ink only.

Do Not Mail This Form-Bring To Registration!

To be completed by parent or guardian. Please PRINT and Please use blue or black ink only.
(For confidential use by camp staff and health care professionals as needed.)

Camper Last Name: _____ Camper First Name: _____

Date of Birth (Month, Day, Year): _____

___ My camper DOESN'T have a preexisting injury.

OR

___ My camper HAS a preexisting injury.

Nature of injury:

Date of injury: _____

Any disability? None _____ Yes _____

If yes, what? _____

Any limitation of physical activities? None _____ Yes _____

If yes, what? _____

Comment or recommendation: None _____ Yes _____

If yes, what? _____

Date of examination : _____

Sign Here → Signature of Physician: _____ Date: _____

Sign Here → Parent/Guardian Signature: _____ Date: _____

ATTACHMENT C
Camper Medication Dispensing Form

Must be completed by the parent/guardian and as need by camper's physician.

Do Not Mail This Form - Please Bring To Registration!
To be completed by parent or guardian. Please PRINT and Please use blue or black ink only.
(For confidential use by camp staff and health care professionals as needed.)

Camper Last Name: _____ Camper First Name: _____

Date of Birth (Month, Day, Year): _____

Prescription medication must be brought in a container appropriately labeled by pharmacy or Physician. All medication must be labeled and prescribed for this camper only. An original prescription labeled bottle must be in our possession before dispensing medications at camp. No medication will be given without this information:

Prescription Medication #1: _____
Dosage: _____
Directions: _____
Reason for prescription: _____

Prescription Medication #2: _____
Dosage: _____
Directions: _____
Reason for prescription: _____

Prescription Medication #3: _____
Dosage: _____
Directions: _____
Reason for prescription: _____

Prescription Medication #4: _____
Dosage: _____
Directions: _____
Reason for prescription: _____

Prescription Medication #5: _____
Dosage: _____
Directions: _____
Reason for prescription: _____

Prescription Medication #6: _____
Dosage: _____
Directions: _____
Reason for prescription: _____

Continued...

**ATTACHMENT C - Continued
Camper Medication Dispensing Form**

Must be completed by the parent/guardian and as need by camper's physician.

Do Not Mail This Form - Please Bring To Registration!

*To be completed by parent or guardian. Please PRINT and Please use blue or black ink only.
(For confidential use by camp staff and health care professionals as needed.)*

Prescription medication must be brought in a container appropriately labeled by pharmacy or Physician. All medication must be labeled and prescribed for this camper only. An original prescription labeled bottle must be in our possession before dispensing medications at camp. No medication will be given without this information:

Over-the-Counter Medication #1: _____
Dosage: _____
Directions: _____
Reason for prescription: _____

Over-the-Counter Medication #2: _____
Dosage: _____
Directions: _____
Reason for prescription: _____

Over-the-Counter Medication #3: _____
Dosage: _____
Directions: _____
Reason for prescription: _____

Sign Here Signature of Physician: _____ Date: _____

I hereby give permission for Camp Downer health care providers to dispense medicine to my child:

Prescriptions listed on front: YES OR NO (Circle One)

ALL PRESCRIPTION MEDICATION WILL ONLY BE DISPENSED AS PRESCRIBED BY THE DOCTOR.

Non-Prescription medication: YES OR NO (Circle One)

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury unless otherwise indicated below.

Acetaminophen (Tylenol), Ibuprofen (Advil, Motrin), Phenylephrine decongestant (Sudafed PE), Pseudoephedrine decongestant (Sudafed), Diphenhydramine antihistamine/allergy medicine (Benadryl), Dextromethorphan cough syrup (Robitussin DM), Sore throat spray, Generic cough drops, Lice shampoo or cream (Nix or Elimite), Antibiotic cream, Calamine lotion, Aloe, Laxatives for constipation (Ex-Lax), Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

Please note any Non-Prescription medications the camper should **not** be given:

Sign Here Parent/Guardian Signature: _____ Date: _____

ATTACHMENT D

Camper Comprehensive Physical Form

(To be completed by the camper's physician as needed, see below)
To be completed by parent or guardian. Please PRINT and Please use blue or black ink only.

Do Not Mail This Form-Bring To Registration!

(For confidential use by camp staff and health care professionals as needed.)

EVERY CAMPER MUST SHOW PROOF OF HAVING HAD A PHYSICAL EXAMINATION WITHIN THE TWO YEARS PRIOR TO ATTENDING CAMP

Please attach a copy of a physical examination form to the Health Statement and Parent/Guardian Approval Form. If this camper has not had a physical within the last two years, this Comprehensive Physical Form OR a signed statement by a physician, clinic or health center, must be completed.

Camper Last Name: _____ Camper First Name: _____

Date of Birth (Month, Day, Year): _____

Camper's Physician Information:

Name: _____ (Last Name, First Name, Middle Initial)

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Medical History (Check any that apply):

- Loss of eye, lung, kidney or other organ
- Loss of vision or hearing
- Loss of consciousness with head injury
- Serious illness in the past year
- Serious accident in the past year
- Exposed to contagious disease in the past month
- Physical/mental/emotional problem we should be aware of
- Takes prescribed medication (Physician must fill out Attachment C Camper Medication Dispensing Form)
- Known sensitivity to any medications
- Medical problems/Diagnosis

Comments on Medical History:

General condition summary:

Check the diseases or vaccinations the individual has had:

- Measles
- Mumps
- German Measles
- Chicken Pox
- Whooping Cough

Sign Here  Signature of Physician: _____ Date: _____

ATTACHMENT E Camper Immunization History Form

All campers must either:

- A) attach a printed report of immunizations from their health care provider, or
- B) complete this Immunization Form (Attachment E) (Please PRINT in blue or black ink) or
- C) complete and attach a Vermont Department Of Health Medical or Religious Exemption Form.

Camp Downer does not accept Philosophical Exemptions.

Do Not Mail This Form-Bring To Registration!

(For confidential use by camp staff and health care professionals as needed.)

The State of Vermont recommends that each camper provide a record showing that immunization requirements have been met. Provide information below from your records or consult your physician.

Camper Last Name: _____ Camper First Name: _____

Date of Birth (Month, Day, Year): _____

DTP, DT or Td or Tdap

Number Of Vaccine	1	2	3	4	5	Ten Year Booster
Date (Month, Day, Year)						
Circle Type Of Vaccine	DTP - DT - Td	DTP - DT - Td	DTP - DT - Td	DTP - DT - Td	DTP - DT - Td	Tdap

POLIO

Number Of Vaccine	1	2	3	4
Date (Month, Day, Year)				
Circle Oral or Injection	ORAL INJECTION	ORAL INJECTION	ORAL INJECTION	ORAL INJECTION

HEPATITIS B

Number Of Vaccine	1	2	3
Date (Month, Day, Year)			

M.M.R. (1st dose must have been received on or after the first birthday. (Measles, Mumps and Rubella) is preferred vaccine.)

MMR

Number Of Vaccine	1	2
Date (Month, Day, Year)		

VARICELLA (Chicken Pox)

Varicella Disease Date _____, or as indicated below

Varivax #1 Date _____ Varivax #2 Date _____

If you wish to claim a Medical or Religious Immunization, you MUST complete and attach a Vermont Department Of Health Exemption Form EVERY YEAR. Camp Downer will no longer accept a Philosophical Exemption.

Medical Exemption Form: <http://healthvermont.gov/hc/imm/documents/Medexemption.pdf>

Religious Exemption Form: http://healthvermont.gov/hc/imm/documents/Philexemption_2013.pdf

Sign Here Parent/Guardian Signature: _____ Date: _____