Camp Lookout Health Information Form

Camper Name _____ **Birthdate** _____ **Age While at Camp**_____

Parent/Guardian _____**Contact Number #**_____

Address_____**Contact Number #**_____

City: _____**State:**_____**ZIP Code:** _____

1. **Emergency Contact Name** _____ **Contact Number** _____

2. **Emergency Contact Name** _____ **Contact Number** _____

ALLERGIES

This camper is allergic to:

- ☐ **No known allergies**
- ☐ **Food**
- ☐ **Medicine**
- ☐ **Environment (bee, wasps, hayfever etc)**
- ☐ **Other**

DIET/NUTRITION

Diet Restrictions:

- ☐ **Regular Diet**
- ☐ **Diabetic** _____**Calorie**
- ☐ **Gluten Free**
- ☐ **Vegetarian**
- ☐ **Food Allergy - Explain in detail (If substitutions necessary, provide substitution)**
- ☐ **Other (Please Explain)**

IMMUNIZATIONS

Is your camper up to date with immunizations? **Yes** **No**

****Attach copy of immunizations.** **Provide last date of tetanus vaccination:** _____

GENERAL HEALTH HISTORY

This camper currently has or has been treated for the following:

Chronic Recurring Illnesses: (Check those that apply and give appropriate dates)

- ☐ **Asthma** _____ ☐ **Diabetes** _____ ☐ **Ear Infection**_____
- ☐ **Musculoskeletal Disorder**_____ ☐ **Bleeding/Clotting Disorders**_____
- ☐ **Mononucleosis**_____ ☐ **Hypertension** _____ ☐ **Seizures/Convulsions**_____
- ☐ **Skin Diseases/MRSA**_____ ☐ **Heart Defect/Disease** _____
- ☐ **Other** _____

Other Health Conditions:

- ☐ **Attention Deficit Disorder (ADD)** ☐ **Down's Syndrome** ☐ **Hearing Impairment** ☐ **Nosebleeds**
- ☐ **Bed Wetting** ☐ **Menstrual Cramps** ☐ **Glasses with/home** **Contacts with/home**
- ☐ **Motion Sickness** ☐ **Sleep Walking** ☐ **Dental Braces** ☐ **Fainting**
- ☐ **Heat Stroke** ☐ **Emotional Disturbances**
- ☐ **Lice Infestation Date**_____ ☐ **Other** _____

Last treatment _____

CURRENT TREATMENT/THERAPY

☐ **This camper is not presently undergoing treatment/therapy.**
☐ **This camper is undergoing treatment/therapy at this time. (List conditions).**

☐ **Treatment/therapy will be continued while at camp.**
(Please describe and discuss with director or camp health professional.)

Comments:

LIMITATIONS/RESTRICTIONS AT CAMP

Please provide additional information about the camper's health that may be important or that may affect the camper's ability to fully participate in the camping experience.

Does the camper have any limitations or restrictions to any of the activities offered while at camp?
Yes No

If you answered "yes", what do you recommend? Describe below.

MEDICATIONS TO BE ADMINISTERED Camper Name ____________________________

☐ **This camper <u>will not take</u> any daily medications while attending camp.**
☐ **This camper will take the following medications while at camp. Please place on list below exactly as administered.**
☐ **This camper will take the following daily vitamins while at camp. Please place on list below.**

Medications/Vitamins need to be in their original medication containers with label and directions from pharmacy or manufacturer. Complete the list of medicines to be administered exactly. Medications not completed on this form will not be administered.

Medications/Vitamins:	Dosage:	Purpose:	When Given:	Specific Instructions for Administering Medications/Vitamins
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other	
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other	
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other	
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other	
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other	
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other	
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other	
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other	

******** Please remember to pick up the medications on Friday night. All medications left at camp will be disposed of if not picked up.**