**Turning Rivers Health Form**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date (MM/DD/YYYY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City / State / Zipcode \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender \_\_\_\_\_\_\_\_\_\_Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Person #2 (if primary contact cannot be reached)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Participant:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CAMPER’S HEALTH CARE PROVIDER**

Family Doctor Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Facility Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City / State / Zipcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS**

Do we have your permission to administer the following to you as needed: Tylenol, Benadryl, Sudafed, Cough Syrup, Caladryl, Tums, Cough Drops, Hydrocortisone Cream, and Neosporin. YES NO

 I WILL NOT take any daily medications while attending camp.

 I WILL take the following medication while attending camp. They will bring enough medication to last the entire session and it will be in the original container labeled by the pharmacy.

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dose | When do you take it at home? | Reason for taking the medication |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**ASTHMA**

I have asthma. YES NO

If yes, please explain what triggers an attack (i.e. exercise, infections, allergies (to what?), weather, emotions) and how the episode is managed.

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**DIETARY RESTRICTIONS**

I have dietary restrictions. YES NO

If yes, please explain what dietary restrictions are needed. Also, include any known food allergies.

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|  |
| --- |
| **HEALTH HISTORY** |
| Condition | provide approximate dates |  | Condition | provide approximate dates |
| Ear Infections |  |  | Asthma |  |
| Heart Defect |  |  | Measles |  |
| Seizures |  |  | Chicken Pox |  |
| Diabetes |  |  | German Measles |  |
| Bleeding/Clotting |  |  | Mumps |  |
| Hypertension |  |  | Hepatitis |  |
| Mononucleosis |  |  | Other |  |

**IMMUNIZATIONS** / Please check one.

 These immunizations are current or up to date.

 For health reasons I am not fully immunized.

 For personal conviction or religious reasons, this child is not fully immunized.

Please check which immunizations I have received:

 DPT Permanent Shots Polio Immunization

 TD (tetanus/diphtheria) MMR (Measles, Mumps, Rubella)

 Tetanus Booster/date \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hepatitis B

Please list any other important medical conditions that may impact camp life.

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Are there any activity restrictions for health reasons?

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Are there any other conditions that we should be aware of that may impact your experience; fears, anxieties, current family situations, etc.?

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**INSURANCE INFORMATION**

Please attach a photocopy of your insurance card / both front and back.

 Check here if I am not covered by health insurance.

 Signature (required) Date

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