2017 CAMPER MEDICAL FORM

Camper Name _____

Address _____

City _____ State ____ Zip _____

Age ____ Birth date ___/___/___ M ___ F___

Select Camp:

☐ Pioneer, June 8-10

☐ Adventure, June 11-17

☐ Pathfinders, June 18-24

☐ Discovery, June 25-July 1

Medical Insurance ☐ Check box to show copy of medical card attached

Each camper and staff person must submit: 1) A completed (both sides) and signed medical form. 2) Photocopy of front and back of health insurance card. Hospitals now need all the billing information and phone number, not just the policy number.
Camp Otyokwah does not provide supplemental medical insurance for campers. Parents or guardians are responsible for medical insurance.

Family Insurance Company _____

Policy # _____

Parent/Guardian or Spouse _____

Date of Last Tetanus Shot:

_____

If more than 10 years ago, should have booster before coming to camp.

Special Conditions/Health History: (please check)

___Bedwetting
___Convulsions/Seizures
___Heart trouble
___Shortness of breath
___Handicap
___Eczema/skin rashes
___Emotional/behavior problems
___Allergies
___Hayfever/asthma/wheezing
___Diabetes
___Sleepwalking
___Speech problems
___Frequent Earaches/Soar Throats
___Recently exposed to infectious diseases (ringworm, lice, etc.)
___Other: please explain _____

Surgeries and/or Hospitalizations:

Date	Reason
_____	_____
_____	_____

Allergies to Medications:

Medication	Type of Reaction
_____	_____
_____	_____

How does the camper react to injury or illness? (i.e. pain tolerance, minimizes injury, dramatic, etc.)_____

Please include other information that will be helpful in an emergency_____

Medications:

Note: The resident Health Professional functions under the direction of a medical director. **Medications may only be administered if in the ORIGINAL BOTTLE.** Medications in plastic bags or other pill containers cannot be dispensed. Medications prescribed to someone other than the camper may not be dispensed.

Medications to be taken during camp:

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____

REQUIRED FOR EACH CAMPER:

If I cannot be reached in an emergency, I give permission to Camp Otyokwah Personnel to provide emergency medical treatment, including hospitalization, for my child. I also give the resident health professional permission to administer nonprescription medications as deemed necessary.

Parent/Guardian's Signature _____

Parent/Guardian's Name (printed) _____

Address _____

Phone (H) ____-____-_____ (W) ____-____-_____ (C) ____-____-_____

Additional Emergency Contact_____

Relationship_____

Phone (H) ____-____-_____ (W) ____-____-_____ (C) ____-____-_____