

CANOE ISLAND HEALTH HISTORY AND CONSENT TO TREATMENT FORM

This form must be filled out and signed by parent/guardian or adult participant to be able to participate in any Canoe Island program. If attending multiple sessions in one year, only one form is required.

Canoe Island French Camp will make every effort to contact parents by phone for all but minor injuries and illnesses their child may experience. We will also call them to consult about behavioral and emotional problems. This information will be seen ONLY by camp staff and professional providers on a need-to-know basis.

Name of participant _____ Date of birth: _____

Address _____

Home Phone _____ Work phone _____ Cell Phone _____

PLEASE CHECK IF PARTICIPANT HAS, OR IS, SUBJECT TO THE FOLLOWING (please explain below).

Asthma _____ Diabetes _____ Fainting _____ Bee sting allergy _____ Heart Trouble _____

Seizures _____ Sleepwalking _____ ADD _____ ADHD _____ Emotional health concern _____

Comments _____

List all medications coming to camp: prescriptions, over the counter meds, vitamins, etc. Keep in original bottle identifying prescribing physician, the name of the medication, the dosage, when they are to be taken, and for what condition. Attach additional pages, if necessary.

Med # 1 _____ Dosage _____ Time taken: _____

Med # 2 _____ Dosage _____ Time taken: _____

Med # 3 _____ Dosage _____ Time taken: _____

List any past medical conditions, including significant injuries, major illnesses: _____

List all allergies, reactions, and describe management of reaction: _____

Describe any restrictions to child's activities while at camp for current medical reasons: _____

Does your child have diet restrictions/preferences? _____

Describe any behavior problems that might be disruptive to group learning: _____

If you feel there are any circumstances that would produce problems in your child's adjustment to camp life, please contact the Camp Director Connie Jones at 360.468.2329. I would be glad to discuss them with you before your child comes to camp. If a medical or behavioral event requires your child to return home early, you will be responsible for providing transportation home.

Give the year of the last immunization or booster, or attach a copy of official immunization record:

Tetanus _____ Chicken Pox _____ Measles/Rubella _____ Mumps _____ Flu _____

Diphtheria/Pertussis (DtaP/DT) _____ Hepatitis A _____ Hepatitis B _____

Has your child had chicken pox? Yes: _____ No _____ Mumps: Yes: _____ No _____

Has your child been exposed to any communicable illnesses within the past few weeks? Yes: _____ No: _____

If yes, describe: _____

The following are the over-the-counter medications we use for common ailments that arise at camp. These are recommended by the physician who oversees our health care. We are limited to dispensing only these medications without further permission from a physician or parent/guardian.

Check here to give permission for the camp to administer the following, if deemed necessary. Cross out any products that you do NOT want your child to have.

For Pain, cough, cold

Tylenol or Aleve
Ibuprofen
Benadryl
Chlor-Trimeton
Robitussin
Sudafed
Choraseptic spray
Cough drops/throat lozenges
Herbal Tea

For digestive upsets

Tums
Peptol Bismo
Altoids or peppermint
Milk of Magnesia

For anaphylaxis, only in life threatening emergency:
Epinephrine

Topical products:

Insect Repellent (with DEET)
Sunscreen
Aloe vera gel
Calamine or caladry lotion
Skin moisturizer
Baking soda or meat tenderizer paste
1% hydrocortisone cream
Antibiotic ointment
2% lidocaine jelly
Gold Bond Medicated Powder
Athlete's foot powder

PHYSICIAN'S STATEMENT

Physician's Name: _____ Phone _____

Please attach proof of a doctor's examination in the past 24 months that indicates that this person is able to participate in an active camp program.

INSURANCE INFORMATION

Please attach a copy of both the front and back of the participant's insurance card.

Is participant covered by family medical/hospital Insurance? Yes _____ No _____

Insurance Company and Plan: _____ Policy # _____

Insurance company address: _____

If parent/guardian cannot be reached in case of emergency notify: Name: _____

Home phone _____ Work phone _____ Relationship _____

PARENTS CONSENT TO TREATMENT:

This health history is correct and complete as far as I know. The person described has permission to engage in all camp activities except as noted. I take full responsibility to see that myself or my child is properly prepared including having proper clothes and equipment and being in good health.

I authorize the camp to provide routine health care, administer medications that I am sending or bringing to camp, as well as any medications recommended by the camp nurse for various problems except as I have noted above. I authorize the camp to share information in this document with selected camp staff and professional health care providers on a need-to-know basis.

If I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. I authorized the camp to arrange and/or provide necessary transportation for my child. This form may be photocopied for trips out of camp.

Signature of parent/guardian or adult camper/staff member: _____

Printed name _____

If for religious or other reasons you wish not to authorize treatment, please attach a letter of explanation signed and dated.