CAMP SUNRISE CAMPER HEALTH RECORD

The health record must be **COMPLETED IN FULL** and signed by parent/guardian and **NOTARIZED** before your registration will be processed.

CAMPER INFORMATION

Last Name________________________________ First Name________________________________ MI _____ ❑ Male ❑ Female

First time at Camp Sunrise? ❑ Yes ❑ No Birth date _____/_____/_____ Age _____

PARENT/GUARDIAN INFORMATION (where camper resides)

Last Name________________________________ First Name________________________________ MI _____

Address ____ Apt. # ____________

City____ State _________ Zip ____________________

Home Telephone ___________________ Business Telephone ___________________ Spouse Name ___________________________

Cell Phone Number ___________________

EMERGENCY INFORMATION (if Parent/Guardian cannot be reached)

Emergency Contact______________________________________ Relationship________________ Telephone ___________________

Family Physician ____ Telephone ___________________

Health Insurance Co. ____ Policy #________________________________

Attach a copy of insurance card - front & back **Medicaid #** ___________________ **Medicare #** ___________________

Policyholder's Birth Date: ____

Prescription drug policy? ❑ Yes ❑ No ***If yes, attach a copy of prescription card - front & back***

NOTE: The Warwick Conference Center / Camp Warwick is not responsible for the cost of prescriptions, doctor visits, or emergency room visits during the camper's stay.

MEDICAL INFORMATION

Is this camper in general good health and able to participate in all normal camp activities? ❑ Yes ❑ No

ADD	❑ Yes	❑ No	Heart Murmur	❑ Yes	❑ No	Throat problems	❑ Yes	❑ No
ADHD	❑ Yes	❑ No	As infant	❑ Yes	❑ No	Respiratory problems	❑ Yes	❑ No
Seizure Disorder	❑ Yes	❑ No	Current problems	❑ Yes	❑ No	Diabeties	❑ Yes	❑ No
Dizzy spells	❑ Yes	❑ No	Chest pain/irregular			Special diet	❑ Yes	❑ No
Motion sickness	❑ Yes	❑ No	heartbeat	❑ Yes	❑ No	Frequent nausea	❑ Yes	❑ No
Chronic back pain	❑ Yes	❑ No	Low/high blood pressure	❑ Yes	❑ No	Jaundice/Hepititis	❑ Yes	❑ No
Chronic neck pain	❑ Yes	❑ No	Ear infections	❑ Yes	❑ No	Difficulty urinating	❑ Yes	❑ No
Homesickness	❑ Yes	❑ No	Hearing problems	❑ Yes	❑ No	Kidney infection	❑ Yes	❑ No
Special needs	❑ Yes	❑ No	Vision problems	❑ Yes	❑ No	Hernia	❑ Yes	❑ No
Hyperactive	❑ Yes	❑ No	Severe menstrual cramps	❑ Yes	❑ No			

FOR GIRLS: Has menstruated? ❑ Yes ❑ No Been told about menstruation? ❑ Yes ❑ No

Auto-immune condition? ❑ Yes ❑ No If yes, please describe below.

Please give specific information and current status regarding any items marked "yes" above.

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MEDICAL HISTORY

Chronic recurring illness ________________________________ Any broken bones ________________________________

Seizure Disorder ________________________________ Contagious diseases ________________________________

Severe head, neck or back injury____

Serious operations (list date/type)____

Recent illness/injury____

Please submit statement of how your child has been medically treated and with what medication.

ALLERGIES

Asthma	❑ Yes	❑ No	Sulpha	❑ Yes	❑ No	Bee Sting	❑ Yes	❑ No
Hay Fever	❑ Yes	❑ No	Penicillin	❑ Yes	❑ No	Suntan Lotion	❑ Yes	❑ No
Latex	❑ Yes	❑ No	Poison Ivy/Oak/Sumac	❑ Yes	❑ No			

Skin: ____

Other:____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

CAMPER HEALTH RECORD

CAMPER NAME____

FOOD ALLERGIES ❑ Yes ❑ No

If "Yes", please list below or attach a separate sheet; indicate the type of allergic reaction.

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What type of reaction does your child experience when ingesting these foods?

Hives . . . . ❑ Yes ❑ No   Anaphylactic Shock . . . . . . ❑ Yes ❑ No

GI Disturbance . . . . . . ❑ Yes ❑ No

What treatment is given?

None . . . . ❑ Yes ❑ No   Benadryl . . . . ❑ Yes ❑ No

Epi-pen* . . . . ❑ Yes ❑ No   Is your child able to self-administer epi-pen? . . . ❑ Yes ❑ No

Other: ____

____

**Requires a doctor's order. Complete Medical Authorization Form in this packet.*

Camp Warwick makes every attempt to accommodate food allergies and sensitivities. However, in cases of potential life-threatening allergies families are encouraged to send their own food and snacks. We encourage you to call two weeks prior to your child attend-

IMMUNIZATION RECORD

PLEASE SUBMIT AN OFFICIAL IMMUNIZATION RECORD FROM THE CAMPER'S DOCTOR'S OFFICE.

The Hepatitis B series is required by Camp Warwick unless 1) it is medically contraindicated (doctor's signature required), or 2) choose not to for religious reasons (documentation by religious leader necessary).

A Tuberculosis (TB/PPD) test must have been completed within the past two years (i.e., dated within two years from the start of the camp week in which the camper has enrolled).

MEDICATIONS

Over-The-Counter Medications: Any over-the-counter medications given to the camper must be pre-approved and signed by the camper's physician. Please complete the **USE OF OVER-THE-COUNTER MEDICATIONS** form enclosed.

Prescription Medications: All prescription medication must be in the original container, labeled with the camper's name and sent with written instructions signed by your physician attached. Please complete the **PARENTAL & PHYSICIAN'S AUTHORIZATION FOR ADMINISTERING PRESCRIPTION MEDICINES** form.

CONSENT RELEASE FOR CAMP SUNRISE

In signing this release, I certify that the information on this form is correct. In case of a medical emergency, I authorize the release of medical records and understand that every effort will be made to contact the parent/guardian. **In the event that the parent/guardian cannot be reached, permission is hereby given to the physician selected by the Warwick Conference Center to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my son/daughter/ward, as named herein.** I understand that I am responsible for the cost of prescriptions, doctor visits and/or emergency room visits during my son/daughter/ward's stay at Camp Sunrise. I authorize the Camp Sunrise Health Director to supervise the self-medication of prescription and over-the-counter medicines by my son/daughter/ward. I give permission for my son/daughter/ward to be transported in the Warwick Conference Center vehicles or other designated vehicles to and from public transportation. I give permission for my son/daughter/ward to be transported in the Warwick Conference Center vehicles as necessary for approved off-site camp activities. I authorize the use of photographs and videos of my son/daughter/ward in camp publicity.

____   _________________________

PARENT/GUARDIAN SIGNATURE   DATE

ACKNOWLEDGEMENT BY INDIVIDUAL

STATE OF ***)***

SS:

COUNTY OF)

On this (day) _________ (month of) ___________, (year)________, before me personally came ____________________________________, to me known and known to me to be the person described in and who executed the forgoing instrument and he/she acknowledged to me that he/she executed the same.

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Notary Public

NOTARIZED HOSPITAL RELEASE STATEMENT REQUIRED BY THE MEDICAL FACILITY AND CAMP WARWICK

OFFICE USE ONLY

NURSE'S NOTES:

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