



Parent-Complete Health Form 2020

Camper Full Name: _____

Birth Date: _____ Age (as of 6/22/2020) _____
 Month / Day / Year

Parent/Guardian and other Emergency Contacts/Picker Uppers **(Please list in the order we should contact in case of an emergency.)**

Name (Please Print)	Pick Up?	Relationship to Camper	Cell Phone	Work Phone / Other
1.	Yes <input type="checkbox"/> No <input type="checkbox"/>			
2.	Yes <input type="checkbox"/> No <input type="checkbox"/>			
3.	Yes <input type="checkbox"/> No <input type="checkbox"/>			
4.	Yes <input type="checkbox"/> No <input type="checkbox"/>			

Allergies: No known allergies.
 This camper is allergic to: Food Medicine The environment (insect stings, hay fever, etc.) Other _____
(Please describe what the camper is allergic to and the reaction. Include medication needed, dosage, and application.)

Diet, Nutrition: This camper eats a regular diet. This camper eats a regular vegetarian diet.
 This camper has special food needs or issues with hunger.
(Please describe below.)

Restrictions: I have reviewed the program and activities of the camp and feel the camper can participate.
 Please provide notes or additional information regarding this camper's participation in the space below:

Medical Insurance Information:
 This camper is covered by family medical/hospital insurance Yes No
 Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.
 Insurance Company _____ Policy Number _____
 Subscriber _____ Insurance Company Phone Number (_____) _____

Parent/Guardian Authorization for Health Care:
 This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. If I cannot be reached in an emergency, I give my permission to Camp Garrett staff to contact emergency services and/or emergency transport to a medical facility if deemed necessary by the Healthcare Provider or Camp Director. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, Camp Garrett has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the camp's staff about my child's health status.
 Parent/Guardian Signature: _____ Date: _____

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Camper _____

Being Prepared for the Camp Environment: *Camp Garrett is a nature camp that takes place outdoors in a fast-paced, community-based environment.*

The following list represents a day in the life at Camp Garrett.

1. Moving around the property in sometimes strenuous conditions (including but not limited to uneven terrain and unpredictable weather) for at least 2 miles every day.
2. Providing self-care in a fast-paced, interactive environment, especially with regards to personal hygiene/ toileting, eating/drinking, dressing, and expressing other needs to staff in a timely manner.
3. Listening to and following verbal directions.
4. Self-moderating emotions in a community-based environment, especially following an event that causes frustration, sadness, anger, or a disruption of normal routine.
5. Recognizing and avoiding unsafe situations for themselves and those around them.

We acknowledge that transitioning to Camp can be challenging. Our goal is to support every child and ensure that we are best prepared to have the safest, kindest, and most fun summer ever! If you have any questions or would like a tour before the summer begins, please contact the office at 610-353-7690.

In the space provided, please share anything we need to know about your child so that we can best meet their needs this summer. *Our goal is to be as prepared to support your camper as possible this summer!*

If your camper has an IEP, Camp Garrett asks for a copy to keep on file. Please attach additional information to this form.

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Camper _____

Camp First Aid

The following non-prescription medications may be stocked in the camp office and are used on an as needed basis to manage illness and injury.

Highlight or cross out the items camper should not be given.

OTHER:

Immunization History: Provide copies of immunization forms from healthcare providers, state or local government. **Please attach to this form or mail or fax them to Camp Garrett by June 8 2020.**

If your camper has not been fully immunized, please sign the following statement:

I understand and accept the risks to my child from not being fully immunized.

Parent/Guardian Signature: _____

Date: _____

Medication: This camper will not take any daily medications while attending camp.

This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. Camp Garrett requires original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp. Please provide instructions in the space below.

Name of medication	Date started	Reason for taking it	Time	Dosage

What Have We Forgotten to Ask? Please provide in the space below any additional information about your camper that will help Camp Garrett Staff meet their needs. Attach additional information if needed.



Physician-Complete Health Form 2020

Camper Full Name: _____ Camper Home Address: _____

Birth Date: _____ Age (as of 6/22/2020) _____ Custodial Parent/Guardian Phone: _____

Physical completed today: Yes No (If "No," date of last physical: _____)
Month/Day/Year

Weight: _____ lbs Height: _____ ft _____ in Blood Pressure _____ / _____

Allergies: No Known Allergies

To foods (*list*):

To medications (*list*):

To the environment (*insect stings, hay fever, etc.—list*):

Other allergies (*list*):

Describe previous reactions:

Medical personnel: Highlight or cross out those items the camper should not be given.

The following non-prescription medications are commonly stocked in our Health Center:

Diet, Nutrition: Eats a regular diet. Has a medically prescribed meal plan or dietary restrictions. (*describe below*)

The camper is undergoing treatment at this time for the following conditions: (*describe below*) None

Medication: No daily medications. Will take the following prescribed medication(s) while at camp: (*name, dose, frequency—describe below*)

Other treatments/therapies to be continued at camp: (*describe below*) None needed.

Do you feel that the camper will require limitations or restrictions to activity while at camp? No Yes
If you answered "Yes" to the question above, what do you recommend? (describe below—attach additional information if needed)

I have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active, outdoor camp program (except as noted above).

Name of licensed provider: _____ Signature: _____ Title: _____

Office Address _____
Street City State Zip Code

Telephone: (_____) _____ Date: _____

This completed form may be faxed to Camp Garrett at 610-356-5156.