

**Due two weeks
prior to camp
attendance**

Mail to:
CSC Registration
Office, 9692
Meadowview Dr.,
Newburg, MD
20664

**Do not fax
health forms.**

Camp St. Charles Health Form

(required for camp attendance)

Name: _____
(camper/staff member)

Date of Birth _____ Age at camp _____

Home Address: _____

Gender: Male Female Session: _____

Custodial Parent or Guardian _____

Home Address (if different from above) _____

PLEASE ATTACH
RECENT PHOTO
OF CAMPER
TO TOP RIGHT
CORNER OF FORM

**FOR OFFICE
USE ONLY**

REV. 09/16

Name: _____ Year _____

Cabin: _____

Name: _____
Last name, First Name

INCLUDE AREA CODES	Mother/Female guardian	Father/Male guardian
Home phone:		
Business phone:		
Cell phone:		

Emergency contact person (other than parents) : _____

Emergency contact phone number: (____)____ - _____

Insurance Information:

Is the camper covered by family medical/hospital insurance? yes no

If yes, indicate carrier or plan name _____

Group # _____ Subscriber name _____

Attach copy of insurance card

Permission to Seek Emergency Medical Treatment: (required for camp attendance)

This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted on this form and discussed with camp director.

I hereby give permission to Camp St. Charles to provide, seek and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

It is my intention that the camp be treated as acting in loco parentis if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability Act of 1996. I hereby agree to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (I) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (II) in the care of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

In the event that I can not 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. *This completed form may be photocopied for trips out of camp.*

Signature of parent or guardian _____
or adult staff member

Date _____ Printed Name _____

**If there are restrictions on
participation in any camp
activity, this area must be
signed by the camper or
staff member.**

**I also understand and agree to abide
by any restrictions placed on my
participation in camp activities.**

Signature of minor or adult staff member

Date: _____

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Name: _____

Health History

Allergies (list all known, medication, food and other allergies):

Allergen	Describe Reaction and Treatment needed
_____	_____
_____	_____
_____	_____

**Food Allergies – Please complete our food allergy online form to provide more detailed information to our kitchen staff*

Medications:

Please list all over the counter and/or prescription medications being taken routinely.

Medications are given at 7:30-8am (breakfast), 11:45am-12pm (lunch), 5:30-5:45pm (dinner) and 8:30-9pm (bedtime/showers). Medication will be given at other times if medically necessary.

This person takes NO MEDICATIONS on a routine basis.

This person takes medication as follows:

Med #1 _____ Dosage _____

Time taken _____ Reason for taking _____

Med #2 _____ Dosage _____

Time taken _____ Reason for taking _____

Med #3 _____ Dosage _____

Time taken _____ Reason for taking _____

Attach additional pages for more medications.

Please list any medications taken during the school year that are not taken during the summer:

Permission for use of Common OTC Medications and Topical Sunscreen and Insect Repellent:

The following is a list of common, minor ailments and the medications used to treat them, as contained in the Camp St. Charles medical protocols. **Please make notes about any special concerns about treatment of these or other minor ailments, including allergies, etc.**

Ailment/Symptom	Medication
Headache/Fever	Tylenol/Advil (or generic equivalent)
Upset Stomach	Tums, Pepto (or generic equivalent)
Vomiting	Emetrol, Nausetrol (or generic equivalent)
Minor Allergies	antihistamine, Benadryl, Claritin
Poison Ivy	anti-itch cream
Insect Bites/Stings	antiseptic, anti-itch cream
Insect repellent (may contain DEET)	applied to campers before campout or whenever deemed appropriate by camp director
Diarrhea	Kaopectate (or generic equivalent)
Sunscreen	Campers are expected to provide and apply their own sunscreen; however, in the case of very young and very fair campers, camp staff may assist campers. Camp staff will assist any campers who request assistance with sunscreen.

Dosage for all of the above medications will be as directed on the package.

In the event that my child were to suffer from any of the common ailments listed above, I give permission for the camp nurse to follow the protocol listed above to treat my child's condition. Furthermore, I give permission for Camp staff to apply insect repellent and/or sunscreen when appropriate.

I hereby permit Camp St. Charles to provide the treatment described above. Camp St. Charles will honor any special instructions noted on this page.

I do not grant permission for Camp St. Charles to administer over the counter medications or topical lotions as described above. This option will require Camp St. Charles medical staff to obtain your verbal permission before treating any non life-threatening emergency, regardless of the date or time of the injury or illness.

Signature of Parent/Guardian

Printed Name of Parent/Guardian

Date

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Name: _____

General Health Questions:

Has/does the camper/staff member...

Yes No

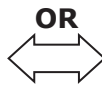
Yes No

- | | |
|--|--|
| <input type="checkbox"/> <input type="checkbox"/> 1. Had any recent injury, illness or infectious disease? | <input type="checkbox"/> <input type="checkbox"/> 15. Ever been diagnosed with a heart murmur? |
| <input type="checkbox"/> <input type="checkbox"/> 2. Have a chronic or recurring illness/condition? | <input type="checkbox"/> <input type="checkbox"/> 16. Ever had back problems? |
| <input type="checkbox"/> <input type="checkbox"/> 3. Even been hospitalized? | <input type="checkbox"/> <input type="checkbox"/> 17. Ever had problems with joints? |
| <input type="checkbox"/> <input type="checkbox"/> 4. Ever had surgery? | <input type="checkbox"/> <input type="checkbox"/> 18. Have an orthodontic appliance being brought to camp? |
| <input type="checkbox"/> <input type="checkbox"/> 5. Have frequent headaches? | <input type="checkbox"/> <input type="checkbox"/> 19. Have any skin problems(rash, acne)? |
| <input type="checkbox"/> <input type="checkbox"/> 6. Ever had a head injury? | <input type="checkbox"/> <input type="checkbox"/> 20. Have Diabetes? |
| <input type="checkbox"/> <input type="checkbox"/> 7. Ever been knocked unconscious? | <input type="checkbox"/> <input type="checkbox"/> 21. Have Asthma? |
| <input type="checkbox"/> <input type="checkbox"/> 8. Wear glasses or contacts? | <input type="checkbox"/> <input type="checkbox"/> 22. Had Mononucleosis in the past 12 months? |
| <input type="checkbox"/> <input type="checkbox"/> 9. Ever had frequent ear infections? | <input type="checkbox"/> <input type="checkbox"/> 23. Had problems with diarrhea/constipation? |
| <input type="checkbox"/> <input type="checkbox"/> 10. Ever passed out during or after exercise? | <input type="checkbox"/> <input type="checkbox"/> 24. Have problems with sleep walking? |
| <input type="checkbox"/> <input type="checkbox"/> 11. Ever had an asthma attack? | <input type="checkbox"/> <input type="checkbox"/> 25. If female, have an abnormal menstrual cycle? |
| <input type="checkbox"/> <input type="checkbox"/> 12. Ever had a seizure? | <input type="checkbox"/> <input type="checkbox"/> 26. Have a history of bed wetting? |
| <input type="checkbox"/> <input type="checkbox"/> 13. Ever had chest pain during or after exercise? | <input type="checkbox"/> <input type="checkbox"/> 27. Ever had an eating disorder? |
| <input type="checkbox"/> <input type="checkbox"/> 14. Ever had high blood pressure? | <input type="checkbox"/> <input type="checkbox"/> 28. Ever had emotional/behavioral problems? |

Please explain any "yes" answers, noting the number of the questions.

IMMUNIZATION INFORMATION:

For campers who reside **within** the United States, a United States territory, or the District of Columbia:



For campers who reside **outside** the United States, a United States territory, or the District of Columbia:

1. State/territory in which child resides: _____
2. Is this child exempt from any immunization?
[] NO [] YES, list them: _____

1. Country in which child resides: _____
2. Attach Department form DHMH-896 (record of vaccination or immunity)

Parent, Legal Guardian or Adult Staff Member's Signature: _____ Date: _____

Use this space to provide additional information about the camper/staff member's behavior and physical, emotional, psychiatric or mental health about which the camp should be aware. Contact the camp director prior to camp to discuss any special concerns or needs that your child may have.

Name of Physician _____ Phone: _____
Address _____
Name of Dentist/Orthodontist _____ Phone: _____
Address _____

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Name: _____

Pages 1-3 of the health form should be completed by parent prior to review by licensed medical personnel.

This page must be completed by Licensed Medical Personnel

I examined this individual on _____(date). (Date of exam must be legible and **within 24 months** of camp attendance. Campers or Staff Members with any medical concerns must have an annual exam. **Camp St. Charles highly recommends an annual physical exam for all campers and staff members.**)

Blood Pressure _____ Weight _____ Height _____

In my opinion, the above applicant is is not able to participate in an active camp program. The applicant is under the care of a physician for the following conditions:

Recommendations and Restrictions at Camp

I have reviewed the medications to be administered at camp. yes no
Treatment to be continued at camp and/or other health concerns.

Name of Licensed Medical Personnel _____
Signature of Licensed Medical Personnel _____
Date: _____
Title _____ Phone: _____
Address: _____

FOR CAMP USE ONLY:

Parent/Guardian meeting with Camp Health staff yes no _____ initials of camp health staff
Updates/Additions to Health Form Noted yes no none required

Other Notes: _____

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