Kirkmont Center Medical Form 2018

Please fill out entire form and mail to Kirkmont Center: 6946 County Rd. 10, Zanesfield, OH 43360.
Must be mailed at least 2 weeks before camp start date.

Today's Date:_____ Camp Attending and Camp Dates:_____
This form is for: □Camper 18 and Under □Adult Camper or Volunteer (over 18) □Staff (over 18)

Name_____ Gender_____ Age_____ DOB_____
Home Address_____
City_____ State_____ Zip_____

Parent/guardian with legal custody to be contacted in case of illness or injury:
Name_____ Relation_____ Email_____
Home Phone (_____)_____ Cell Phone (_____)_____ Work Phone (_____)_____
Home address (if different from above)_____

Second parent/guardian or other emergency contact: Custodial Parent? □ Yes □ No
Name_____ Relation_____ Email_____
Home Phone (_____)_____ Cell Phone (_____)_____ Work Phone (_____)_____

Additional contact in event parent(s)/guardian(s) cannot be reached:
Name_____ Relation_____ Email_____
Home Phone (_____)_____ Cell Phone (_____)_____ Work Phone (_____)_____

Note: Emergency contact will usually be called in cases of: persistent fever of 101+, contagious illness, lice, health center stay over 24 hours, or injury/illness requiring care beyond our health center. You will also be contacted in cases of exceptional discipline or homesick situations.

Health Insurance: Do you have medical insurance? □ Yes □ No

_____
Name of Policy Holder Policy Holder Phone Number
Employer Name (if insured through company) _____

_____
Insurance Company/Plan Name Insurance Company Phone Number

_____
Insurance Company Policy Number Insurance Group Name or Number

Allergies:

□ No allergies □ Food allergies □ Medicine allergies □ Other (insects, environmental, etc.)
Does allergy require an Epipen?_____ Please describe camper allergy, treatment and reaction seen:_____
_____

General Health History:

YES/NO
- □ □ Headaches/Migraines, Frequency:_____
- □ □ Skin Problems
- □ □ Recurrent/Chronic Illness:_____
- □ □ Asthma, Treatment_____
- □ □ Sleepwalking/Sleep Concerns
- □ □ Ever been hospitalized? Date/Why_____
- □ □ Surgery, Type/Date_____
- □ □ Any Current Health Conditions?_____

YES/NO
- □ □ Ear Infections, Frequency_____
- □ □ Seizures, Frequency_____
- □ □ Diabetes
- □ □ Problems with Diarrhea/Constipation
- □ □ Recent Injury, Date/Injury_____
- □ □ Bedwetting
- □ □ Hearing, Cognitive, Neurological Impairments _____

Mental/Emotional/Social Health History:

YES/NO
- □ □ Ever been treated for Attention Deficit Disorder (ADD) Or Attention Deficit/Hyperactivity Disorder(AD/HD)?
- □ □ Autism/Asperger Syndrome; other:_____
- □ □ During the past 12 months, seen a professional to address mental/emotional health concerns?
- □ □ Had a significant life event that continues to affect the camper? Explain:_____

YES/NO
- □ □ Eating disorder?
- □ □ Mood disorder?

Medication:

All medications must be in the original containers and must be turned into the camp nurse at registration. This includes over the counter medication and vitamins. ☐ **Takes no medication on a routine basis**

Attach an additional form if needed:

	Medication #1	Medication #2	Medication #3
Name of Medication			
Dosage			
Times Taken			
Reason			
Other Information			

*Medications are typically given at meals, mid-afternoon and before bed.

Over the Counter Medications:

Please indicate which medications the Camp Nurse can administer for minor illnesses or injuries. Dosages will be administered according to the directions on the medical container.

YES/NO

☐ ☐ Acetaminophen (Tylenol)
☐ ☐ Ibuprofen (Advil, Motrin)
☐ ☐ Cough drops or Lozenges
☐ ☐ Sore throat spray - Chloraseptic or Generic
☐ ☐ Pseudoephedrine decongestant (Sudafed)
☐ ☐ Cough syrup (Dextromethorphan)

YES/NO

☐ ☐ Antihistamine/allergy medicine **(**Benadryl/Zyrtec/Claritin)
☐ ☐ Anti-diarrheal-loperimide (Immodium)
☐ ☐ Stomach ache - Tums or Bismuth subsalicylate (Pepto-Bismol)
☐ ☐ Antibiotic cream (Bacitracin or Neosporin)
☐ ☐ Sunburn treatment (Aloe gel)
☐ ☐ Skin rash/bug bites-Hydrocortisone cream or anti-itch gel
☐ ☐ Poison ivy/oak Ivy Dry/Calamine lotion,

Immunization History:

I, custodial parent, attest that all immunizations, as required for school, are up to date: ☐ YES ☐ NO

Date of last tetanus shot:_____

Camper's Physician_____ Phone_____

Dentist/Orthodontist _____ Phone_____

Please list any activity restrictions or additional information:

_____

_____

I_____ the parent/guardian of _____ Give Kirkmont Center permission to:

1. Provide medications brought to camp by parent/guardian or prescribed by a physician while in attendance.
2. Provide over the counter medications following the dosage and directions on medical container.
3. Without limitation, or obligation, any and all media, including photographs, film footage, or tape recordings, which may include my child's image or voice for the purpose of art, advertising, education, or promotion or for any other purpose, and release the camp from any claim or liability to that use.
4. Agree to hold harmless Kirkmont Center, employees and volunteers for all claims alleging bodily injury or property damage occurring while the participant is at a sponsored activity on or off the Kirkmont premises.
5. Give permission, as necessary to search a camper's belongings when the health, well-being, or safety of the camper or others requires it.

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. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. 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, the camp 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 program's staff about my child's health status.

Signature of Parent/ Guardian, Adult Camper/Staff_____ Date_____

****Please notify Kirkmont Center no fewer than 2 weeks prior to arrival if you or your child have the need for special treatment beyond oral medications (i.e. epi-pens, seizures requiring Diastat or Versed, or diabetics requiring insulin injections, even if they are able to self-administer the insulin.)**