Housing:

Counselors:

Health and Authorization Form

To be filled in by legal parents/guardian of minors or by adult campers/staff themselves.

Contact Information

Name_____Birth Date_____Gender: _____ Age at Camp _____

Home Address_____State _____ Zip _____

Custodial Parent or Guardian_____Preferred Phone_____ 2nd Phone _____

Home Address (if different from above)_____ State_____ Zip _____

2nd Parent/Guardian_____Preferred Phone_____ 2nd Phone _____

Emergency Contact_____Phone_____ Relation to Camper _____

Information Requested by Emergency Medical Services

Family Hospitalization Ins. Co._____Name of Insured_____

Insurance Address_____Policy/Group #_____

Parent/Guardian's Name_____ Employer_____

Office Address_____Office Phone_____

Parent/Guardian's Name_____Employer_____

Office Address_____Office Phone_____

Family Physician _____Address_____ Phone _____

Dentist/Orthodontist _____ Address _____ Phone _____

Authorizations

I verify that the information on this and Health History and Authorization Form is correct and complete as far as I know. I hereby give permission to the camp to provide routine health care, administer prescribed medications as listed herein, administer over-the-counter medications as listed herein, and seek emergency medical treatment. I agree to the release of any records necessary for emergency purposes. I give permission to the camp to arrange necessary emergency medical transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment for my child including ordering x-rays, administering tests, and admittance to a hospital, and I understand that Overlook provides only limited secondary medical insurance coverage for participants

I understand that my child will be participating in many physical activities (including, but not limited to those listed in the program descriptions) and the potential for accidents exists, and give permission for my child to participate fully and to engage in all camp activities unless otherwise noted in the RESTRICTIONS section of this form. I indemnify and hold harmless Camp Overlook, Inc., the United Methodist Church, and its staff and officers from any and all liability, claims, damage, injury or illness sustained by my child. Should it become necessary for my child to return home because of illness or other reason, I will abide by the Camp's decision and arrange for transportation. I understand that there are no refunds for partial camp attendance or early departure. By registering my child into a program which includes transportation off site (i.e.: adventures, trips, service projects), if applicable, I permit my child to leave the grounds of Camp Overlook accompanied by authorized camp personnel for approved out-of-camp activities. I permit camp photos, video and audio of activities or interviews that may include my child to be used in camp promotion without liability or remuneration.

Parent or legal guardian: Signature _____ Printed name: _____ Date: _____

Campers Name_____

Health History

The following information must be filled in by the parent/guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care.

List all known Describe reaction and management of the reaction.

MEDICAL ALLERGIES (list)

_____ _____

_____ _____

_____ _____

FOOD ALLERGIES (list)

_____ _____

_____ _____

_____ _____

OTHER ALLERGIES (list) - include insect stings, hay fever, asthma, animal dander, etc.

_____ _____

_____ _____

_____ _____

IMMUNIZATIONS Information helpful to **EMS**. Provide what you can. Yes/No Last date if known.

Had the following: Vaccinated for the following:

__Measles __Chicken Pox __Hepatitis __ DPT __ TD (Tetanus/diphtheria) __ Hepatitus B __ Hemophilus Influenza B

__German Measles __Varicella Zoster __ Mumps __ Tetanus __ Polio __ Rubella __ Date of last TB Mantoux Test Result

RESTRICTIONS The following restrictions apply to this camper: Attach extra pages if necessary.

Dietary _____

_____ _____

Activities: (e.g. what cannot be done, what adaptations or limitations are necessary) _____

_____ _____

_____ _____

MEDICAL HISTORY: Describe any injury, illness, disease, treatment, surgery, or affliction the camp or Emergency Medical Services should know about.

_____

_____ _____

_____ _____

ADDITIONAL INFOMATION: Information about the participant's behavior, and physical, emotional, or mental health that the camp should be aware.

_____ _____

_____ _____

Camper's Name________________________________ Housing Unit____________ Counselors ______________________

MEDICATION INSTRUCTIONS

If your camper is to take any medication being sent from home, precise instructions are to be recorded here. All medications are stored and dispensed by the Camp Nurse unless special arrangements are made through the Nurse and Camp Director. We suggest that you only send a 5 day supply. Prescriptions should be in the original container. OTC medications should be in original packaging and carefully labeled to include camper name and dosage if less than recommended on the box.

Schedule of Dosages

Please try to coordinate medication times with meals times and bed time. It is difficult to keep up with odd schedules with many children in camp. Please make a large circle at each medication time. The Nurse will initial inside these circles when the dosage hasbeen dispensed. If medication *must* be dispensed at different time, please note.

B = Breakfast, 8:00 a.m. **L = Lunch, 12:15 p.m.** **S = Supper, 5:30 p.m.** **N = Bedtime, 9:30 p.m.**

Medication Name Dosage	Sunday N	Monday B L S N	Tuesday B L S N	Wednesday B L S N	Thursday B L S N	Friday B L S
_______SAMPLE _______________	_O_	__ __ _ O	__ __ __ __	__ __ __ __	__ __ __ __	__ __ __
________________________________	_____	__ __ __ __	__ __ __ __	__ __ __ __	__ __ __ __	__ __ __
________________________________	_____	__ __ __ __	__ __ __ __	__ __ __ __	__ __ __ __	__ __ __
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________________________________	_____	__ __ __ __	__ __ __ __	__ __ __ __	__ __ __ __	__ __ __
________________________________	_____	__ __ __ __	__ __ __ __	__ __ __ __	__ __ __ __	__ __ __

Medication As Needed Instructions (PRN)

Please identify medications you are sending in case they are needed and a description of the condition for which you feel they should be administered.

Medication Name	Dosage	Specific Conditions and Directions
____________________	____________________	____
____________________	____________________	____
____________________	____________________	____

Over the Counter Medications

In case of headache, low grade fever, slight upset stomach, mild diarrhea, mild allergic reactions or cold symptoms, the camp medical staff have my permission to administer the following to my child: (Check the box to the left of each medication allowed.)

__ Antacids (like Tums) __ Anti-diarrheal (like Imodium) __Decongestants (like Sudafed) __ Cold/cough medicine __anti-itch cream

__ Throat lozenges __ Tylenol (or generic) __Advil (or generic) __ Benadryl (or generic) other____________

Nurses' Notes