Camper Health History Forms (please mail completed form to us as soon as you can) CAMP OLIVER

PO BOX 206 DESCANSO, CA 91916

Camper Name:____ Birth Date:__________Age:_______Sex:_____
(Last) (First) (Initial)

Address:________________________________City:__________________State:____Zip:________Phone:__________

Parent/Guardian 1: Name:_________________________Work:______________________Cell:______________________

Parent/Guardian 2: Name:_________________________Work:______________________Cell:______________________

Emergency Contact: Name:________________________Phone:______________________Cell:_____________________

Medical Information:

Family Physician:________________________________Phone:____________________Date of last physical exam________

Medical Insurance Carrier:______________________________Policy and/or Group#:______________________________

Medical Information past or present (please check).

Currently under Dr. care	óYes óNo	ADD/ADHD	ñYes ñNo	Measles	ñYes ñNo
Heart Defect/Disease	óYes óNo	Head Lice (recent)	ñYes ñNo	German Measles	ñYes ñNo
Recent Hospitalization	óYes óNo	Bedwetting	ñYes ñNo	Other Diseases or Conditions	ñYes ñNo
Asthma	óYes óNo	Sleepwalking	ñYes ñNo	________________________	
Seizures	óYes óNo	Tuberculosis	ñYes ñNo	________________________	
Diabetes	óYes óNo	Chicken Pox	ñYes ñNo		

For each Yes, Please explain:____

Allergies:

Hay Fever	ñYes ñNo	Bee Stings	ñYes ñNo	Penicillin	ñYes ñNo
Poison Oak/Ivy	ñYes ñNo	Bee Sting Kit?	ñYes ñNo	Other Drugs	óYes óNo
Foods	ñYes ñNo	Other insects or animals	ñYes ñNo	Any other allergies?	óYes óNo

____

Dietary Restrictions? óYes óNo____

Any reason to restrict full activity including swimming, long hikes, strenuous physical games?: óYes óNo

If Yes, please explain:____

Medication: Please see attached page if your child will be bringing medication to camp, this includes any over the counter medication or vitamins.

Non-Prescription Medications: I authorize the following medications to be administered if deemed necessary by Camp Oliverøs Health Supervisor:

Tylenol	óYes óNo	Benadryl	óYes óNo	Kaopectate	óYes óNo	Cough Syrup/Drops	óYes óNo
Ibuprofen	óYes óNo	Decongestant	óYes óNo	Camphophenique	óYes óNo	Calamine Lotion/Cortaid	óYes óNo

AUTHORIZATION OF CONSENT FOR TREATMENT OF A MINOR: The following MUST be completed.

(I) (We), the undersigned, parent(s) of _________________________, a minor, do hereby authorize the staff of Camp Oliver, as agent(s) for the undersigned, to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is to be rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the California Medicine Practice Act on the medical staff of a licensed hospital, whether such examination, diagnosis or treatment is rendered at the office of said physician or at such a hospital.

It is understood that this authorization is given in advance of any specific examination, diagnosis, treatment or hospital care being required, and is given to provide authority and power on the part of our above-named agent(s) to give specific consent to any and all such examinations, diagnoses, treatments or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable. This authorization is give pursuant to the provisions of Section 25.8 of the Civil Code of California. This authorization shall remain effective until Camp Oliver receives written notification from you canceling this consent form.

______________________________________ ______________________

Parent/Guardian Signature Date

Health Examination to be completed by Licensed Medical Personnel

Note: We require a Health Exam by licensed medical personnel within 24 months of camp attendance.
If your child has had a health exam within the last 24 months, please attach the signed and dated copy here.

Child's Name:______________________________________ Birth date:________________________ Sex:________________

Parent's Name:____

We ask for your written authorization prior to the child's attendance at Camp Oliver. Please realize that camp is held at over 3400 feet elevation and the programs are very active. We have strenuous hiking, games, swimming and camp activities. Your careful consideration is appreciated.

I have examined the child named on this form within the past two years. Date of Exam:_______________

After examination and my review of his/her health history, it is my opinion that this person is physically able to engage in camp activities, except as noted below.

Height:________________________Weight:__________________________ Blood Pressure:__________________________

Is the applicant under the care of a physician for any conditions? ï Yes ï No

Please explain:____

Are there any restrictions in any of the physical programs (hiking, swimming, games, etc.)? ________________________

Any medically prescribed meal plan or dietary restrictions?____

Any treatment or medications to be continued at camp (Please give specific dosages):___________________________

Any Allergies? (Food, drugs, plants, insects, etc):____

Additional health information for camp staff:____

____

Immunization History: Please give the date of immunization or attach copy of record.

Tetanus__________________ Polio___________________ Mumps_______________ Rubella__________________

Diphtheria________________ Chicken Pox ________________ Measles_________________ Other____________

Licensed Medical Personnel Signature:____

Printed:____ **Title:**____

Address:____**Phone:**__________________

If your child has medication, please fill out this form

Office use only
Cabin ________
Gender M / F Age

MEDICATION INSTRUCTIONS

Child's Name____________________________ Session __________________________

Child's Physician Name_____________________ Physician Phone #______________

Please read these instructions carefully

DO NOT PACK YOUR CHILD'S MEDICATION

Bring medication with you to check in. You will discuss treatment instructions with our Health Care Supervisor and your child.

Your child's medication will be administered as prescribed or as instructed if it is Over The Counter.
All medication must meet these requirements.
If requirements are not met, Camp Oliver will **not** be able to dispense medication to your child.

If medication has been prescribed by a Physician…

1. **Medication must be in original bottle with label stating Physician's name, Child's name, name of medication, dosage and expiration date. MEDICATION MUST NOT BE EXPIRED.**
2. **Please discuss your child's condition with our Health Care Supervisor.**

If medication is over the counter…

1. **Medication must be in original packaging.**
2. **MEDICATION MUST NOT BE EXPIRED, PLEASE CHECK EXPIRATION DATE!**

PLEASE FILL OUT BELOW BOX FOR INSTRUCTIONS ON ADMINISTERING YOUR CHILD'S MEDICATION.

Name of medication	Dosage	Number of times/day	Reason

Does this medication need to be refrigerated? Yes / No Name of Medication _______________

Please tell us about your Child's condition ____________________________________

____

____

PLEASE SEE REVERSE SIDE

Please complete Section A if your child has an Asthma Inhaler, Epi-Pen or Insulin.

SECTION A-
Due to the potential necessity for immediate medication distribution imposed by my child's life-threatening allergic response or asthma, I hereby request that______________________ be allowed to keep the appropriate prescribed medication on his/her person while participating in all Camp Oliver activities.

The prescribed device is (check one) **MAKE SURE MEDICATION HAS NOT EXPIRED!**

□ **Epi-Pen** □ **Asthma Inhaler** □ **Insulin** □ **Other *please explain*___________________**

I understand that to qualify for this exemption my son/daughter must be capable of safely storing the necessary asthma, diabetes or allergy medication on his/her person and using the medication appropriately if needed. I agree to release Camp Oliver, the Sisters of Social Service and its agents from all liability arising as a result of this waiver.

Parent/Guardian Signature_____________________________Date________________

SECTION B-
Please read carefully, sign and date below.

I request that Camp Oliver sees that my child is provided with the medication as indicated on these forms under the following conditions:

1. I give Camp Oliver permission to administer the medications on this form as per the instructions on the prescription.
2. Camp Oliver is relying on my judgment as a parent (or guardian) in permitting my child to attend Camp Oliver in view of the health problem which necessitates this medication. However, Camp Oliver reserves the right to refuse my child because of his/her health problem, pursuant to Section DN 212.1 of the California Administrative Code.
3. I certify to Camp Oliver that my child's prescription is valid.
4. I agree to hold Camp Oliver, its directors, officers, agents, and employees, harmless from any loss, cost or expenses arising in any manner from this request.

____________________________ ____________________________
Parent/Guardian Signature Date