

CAMP CALVIN HEALTH & AUTHORIZATION FORM - 2017

This form **MUST BE DUPLEX PRINTED - FRONT AND BACK ON ONE SHEET OF PAPER**, must be completed by a parent/guardian, and must be received by June 1 (late fee of \$25 if received after June 1)

| | | | |
|---|----------------------|---|-------------------------|
| Camper Name: _____ | | Sex: M / F | Race: _____ |
| Age: _____ | Date of Birth: _____ | Church: _____ | |
| Home Address: _____ | | City: _____ | State: _____ Zip: _____ |
| Parent/Guardian: _____ | | Phone: () _____ Cell: () _____ | |
| Emergency Contact Person: (other than parent/guardian) | | Phone: () _____ Cell: () _____ | |
| Emergency Contact Person's Address: _____ | | | |

Health Insurance: YES NO Policy in name of: _____

Insurance Company: _____ Insurance Policy Number: _____

Do you have any health concerns for the camper while at camp? YES NO If yes, please explain:

Will the camper require any dietary modifications while at camp? YES NO If yes, please explain:

If needed, Camp Calvin nursing staff will provide the following over-the-counter medications to your camper. Please check any medications that we do **NOT have your permission** to give your child:

Tylenol (Acetaminophen) Advil (Ibuprofen) Benadryl Claritin Tums Anti-itch Creams Eye Drops

The camp nurse has these and some other common over the counter medications for common ailments (headache, diarrhea, cough or colds). Please do not send these to camp. For safety reasons and by state regulation, any other medications the camper takes must be inventoried, held, and distributed by the camp nurse. Campers may not keep any medications (including inhalers) in their cabins. All medications must be in their *original* packaging or prescription bottle labeled exactly as it is to be given. If the camper takes the medication differently than the prescription on the bottle, it must be accompanied by a written physician prescription form.

Is the camper taking any prescription and/or over the counter medication **on a daily basis**? Please list in the table below.

| <i>Medications Needed or Used</i> | <i>Frequency & Times</i> | <i>Dosage</i> |
|-----------------------------------|------------------------------|---------------|
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IMPORTANT: Please notify the camp if this camper is exposed to any communicable disease during the 3 weeks prior to camp attendance.

| HEALTH HISTORY | | Approx. Dates |
|-----------------------------|-------|-----------------------|
| Frequent Ear Infections | Y / N | |
| Heart Defect/Disease | Y / N | |
| Seizures | Y / N | |
| Diabetes | Y / N | |
| Bleeding/Clotting Disorders | Y / N | |
| Hypertension | Y / N | |
| Mononucleosis | Y / N | |
| Chicken Pox | Y / N | |
| Measles | Y / N | |
| German Measles | Y / N | |
| Mumps | Y / N | |
| ALLERGIES | | Date of Last Reaction |
| Ivy Poisoning, etc. | Y / N | |
| Insect Sting | Y / N | |
| Penicillin, or other drugs | Y / N | |
| Hay Fever | Y / N | |
| Asthma | Y / N | |
| Other | Y / N | |

Operations or serious injuries (include dates):

Disability of chronic or recurring illness:

Are there any other special conditions such as bed-wetting, fainting, sleep walking, etc. which the camp staff should be aware of? If yes, please explain:

| | |
|---|----------------|
| Name of Dentist/Orthodontist: | Phone: () |
| Name of Family Physician: | Phone: () |
| Name of Current Pharmacy for Prescriptions: | Phone: () |

PARENT'S AUTHORIZATION: This health report is correct to the best of my knowledge, and the person herein described has permission to engage in all prescribed activities, except as noted by me. In the event I cannot be reached in an **emergency**, I hereby give my permission to the physician selected by the Camp Calvin Staff to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child as named above.

HOLD HARMLESS AGREEMENT:
Camp Calvin is a Christian Camp held for our children. Many activities occur and are all under the supervision of our volunteer staff, as well as Camp Whitcomb staff. As with all camps, however, injury and/or illness can occur.

I, as a parent or guardian, assume all liability for the action and conduct of my child during Camp Calvin. I agree to release Camp Calvin and staff, as well as Camp Whitcomb and staff from all liability in the event of an injury or illness.

I hereby give my permission to Camp Calvin staff to take photos and/or video of my child for use in online, printed, or digital promotional materials for Camp Calvin.

SIGNATURE OF PARENT/GUARDIAN _____ **DATE** _____

To e-mail us with questions regarding the Health & Authorization Form, please visit our Contact Us page at www.CampCalvin.com.

Please review this form to ensure that it is complete before mailing. We will only accept forms that have been duplex printed (front and back on ONE sheet of paper). A \$25 Late Payment & Health Form Fee will be charged for all payments and Health & Authorization Forms received after June 1.

Mail completed Health & Authorization Form by June 1 to:
Kari Hogfeldt
224 Hidden Bluff Road
Cedar Grove, WI 53013