

Camp Buckeye

Staff Medical Form 2011

Camper's Last Name _____ First Name _____ Date Attending Camp _____
 Address _____ Phone _____
 Age _____ Birthdate ____/____/____ Sex _____ Height ____ ft. ____ in. Weight _____
 Parent/Guardian's Name _____ Daytime Phone _____
 Parent/Guardian's Name _____ Daytime Phone _____
 Other Emergency Contact _____ Daytime Phone _____
 Family Doctor's Name _____ Doctor's Phone _____
 My insurance is with _____ Policy Number _____

Allergies:

- Medications _____ Insects stings or bites Animals _____
 Seasonal (e.g. Hayfever) Foods _____ Other _____

Please describe reactions and treatments for any allergies _____

Please check if camper carries Epipen Medical Alert Bracelet Inhaler

General Health:

- Please check if any of the following conditions apply to the camper
- | | | | |
|---|---------------------------------------|--|--|
| <input type="checkbox"/> Ear Aches | <input type="checkbox"/> Seizures | <input type="checkbox"/> Attention Deficit (ADD) | <input type="checkbox"/> Skin Conditions |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Homesickness | <input type="checkbox"/> Sinus Infections | <input type="checkbox"/> Heart Conditions |
| <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Head Aches | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emotional Concerns | <input type="checkbox"/> Stomach Aches |
| <input type="checkbox"/> Asthma (Please indicate whether or not the camper must carry inhaler at all times) | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please explain extent of health issues, _____
 issues checked above, and _____
 treatments given.

Are all required immunizations current? Yes No

Please list any food allergies. _____

Please list any recent illnesses, injuries, or operations. _____

Please list any activity that should be limited while at camp and why. _____

Medications:

Please list any medications that the camper is currently taking and bringing to camp, using the table below. **Medication MUST be in original bottle or blister pack.** Camper's name, name of medication, and dosage information must be clearly visible. Campers are not permitted to keep any medications in their cabins.

Prescription Medication	Dosage	Time of Day		As Needed Medication	Dosage	Reason for Giving

Does the camp's medical personnel have your permission to administer over-the-counter medications Yes No
 to your child, as required? (Such as Tylenol, antihistamine, antacid, etc.)

I give my permission for the above named camper to take a full and active part in the program at Camp Buckeye and to receive medical treatment in the case of an accident which may occur while he/she is registered at Buckeye. I understand that sickness is not covered by insurance. If medical treatment is necessary, I give permission to take the above named camper to a doctor. I further give permission & request that the named Rx medication(s) be given as ordered on the pharmacy container.

Signature: _____ **Name (please print)** _____ **Date:** _____

Signature: _____ **Name (please print)** _____ **Date:** _____