MEDICAL INFORMATION FOR NATURE CAMP - 2010

Please fill out all four pages and return within four weeks of the start of camper's session to

(*before June 10*): Philip Coulling, Exec. Director
835 Sugar Creek Rd.
Lexington, VA 24450

(*after June 10*): Nature Camp
316 Nature Camp Trl.
Vesuvius, VA 24483

If possible, please arrange for camper to have examination by physician no more than four weeks prior to the start of his or her session so that medical information will be as up to date as possible.

PARENTS / GUARDIANS

Please fill out this form completely before presenting to physician. Use additional sheet if necessary.

Camper's Name: _____ Session: _____ □ Male □ Female

Address: _____ City: _____ State: _____ Zip: _____

Social Security # _____ Date of Birth: _____ Age on arrival at Camp: _____
(*required by camp medical insurance*)

Medical Insurance Information:
This camper is covered by family medical/hospital insurance: □ Yes □ No

Please include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company: _____ Policy Number: _____

Subscriber: _____ Insurance Company Phone # (_____) _____

Camper's Medical History:
List any medications or pills to be taken regularly at camp and directions for their use:

List any other medications taken at home:

Drug allergies: □ Yes □ No
If yes, please list drug and reaction (e.g., amoxicillin caused rash).

Chronic medical problems: □ Yes □ No
If yes, please list (e.g., asthma, diabetes).

If camper has ever been admitted to hospital overnight, please list year and diagnosis.

List any past surgical procedures and significant orthopedic injuries (fractures or bad sprains).

Does the camper have any allergies to insect bites, stings, spiders or food allergies? □ Yes □ No
If yes, note date, reaction and treatment.

NOTE: Nature Camp will strive to accommodate individual dietary restrictions, but if camper has food allergies, please consider bringing alternative food items to leave with the cooks and discussing particular needs with them.

Does the camper need corrective lenses? □ Yes □ No
If yes, _____ glasses and or _____contacts

Has the camper ever been seen by a psychiatrist or psychologist? □ Yes □ No
If so, for what?

Has camper ever:

- passed out or fainted? □ Yes □ No
- been told s/he has a heart murmur? □ Yes □ No
- had a seizure? □ Yes □ No
- received a transfusion of blood products? □ Yes □ No
- been exposed to TB? □ Yes □ No
- been thought to have an eating disorder? □ Yes □ No

Is there any family history of: (*If yes, please explain*.)

- heart disease at a young age (<30 years)? □ Yes □ No
- passing out or dying at a young age? □ Yes □ No

FOR FEMALE CAMPERS ONLY:

Age at onset of menstrual periods: _____
Has camper ever missed more than two periods? □ Yes □ No

Parent/Guardian please note:

1. Nature Camp has some common, over-the-counter medications, as well as other first aid items available for the camper's health. (See back page.) Any medication (prescription or over-the-counter) brought by camper must be registered with the camp's Infirmary Staff at check in, so that we may monitor treatment. (We must be certain that campers are not treating themselves or others without our knowledge.)

2. In an effort to reduce infectious outbreaks at camp, please notify Nature Camp if your child has any illness in the week prior to session start (such as chicken pox, vomiting or diarrhea, bad head or chest cold).

3. You may be requested to talk to Infirmary Staff on arrival at camp if:
   - camper has medication to be checked in.
   - there is a need for further medical information or clarification.
   - this medical form is incomplete.

Please list name and telephone number of camper's regular medical providers.

Name of primary doctor(s): _____ Telephone # (_____)_____

Name of dentist(s): _____ Telephone # (_____)_____

Name of orthodontist(s): _____ Telephone # (_____)_____

Immunization History: Provide the month and year for each immunization. Immunizations marked with an asterisk (*) must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria, tetanus, pertussis * (DTaP or TdaP)						
Tetanus booster * (dT or TdaP)						
Mumps, measles, rubella * (MMR)						
Polio * (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) □ Had chicken pox Date:						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date:	□ Negative □ Positive

If camper has not been fully immunized, please sign the following statement: **I understand and accept the risks to my child from not being fully immunized.**

Signature of Custodial Parent / Guardian : _____ Date: _____ Relationship to Camper: _____

PHYSICIAN

Please review prior information for accuracy and fill out information below.

Patient's Vital Signs: Weight _____ lbs Height _____ ft _____ in Baseline temperature _____ ^{o}F

Vision (with or without corrective lenses): Right 20/_____ Left 20/_____ BP _____

Please describe any heart murmur or vascular bruit.

List any abnormalities on physical exam.

Activities at Nature Camp can be strenuous. Are there any restrictions on activity or specific precautions which should be noted?

Name of licensed provider (print): _____ Signature: _____ Title: _____

Office Address: _____
Street City State Zip Code

Telephone # (_____) _____ Date of exam: _____

The following non-prescription medications may be stocked in the Nature Camp infirmary and are used as needed to manage illness and injury. ***Please cross out those which the camper should not be given.***

Acetaminophen (Tylenol)
Ibuprofen (Advil)
Naproxen sodium (Aleve)
Sudafed, etc. (does not contain pseudoephedrine)
Dayquil
Nyquil
Ricola cough drops
Tavist-D
Benadryl capsules, syrup (antihistamine)
Hydrocortisone
Cepacol throat spray
Epi-pens
Excedrin (contains acetaminophen, aspirin, caffeine)
Advil cold/sinus
Robitussen expectorant, cough suppressant, nasal decongestant
Sterile saline solution
Hydrogen peroxide
Arniflora gel
Medsporin
Alcohol swabs
Povidine – iodine solution (Betadine)
Non-powder, vinyl gloves (non-latex)

EMERGENCY CONTACT INFORMATION – *Please provide telephone numbers for individuals to be reached in the event of an emergency. Please indicate the type (e.g., home, work, cell, pager) for each number.*

Name	Relationship to camper	Phone # 1	Type	Phone # 2	Type	Phone # 3	Type

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 Nature 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 Nature Camp staff. I give permission to photocopy this form. In addition, Nature 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.

Name of Custodial Parent / Guardian (print): _____ Relationship to Camper: _____

Signature for *emergency* treatment: _____ Date: _____

Signature for *non-acute* treatment: _____ Date: _____