EMERGENCY MEDICAL FORM – LAKESIDE 2011 – This form does not need to be notarized.
Please bring to Lakeside with copies of front and back of insurance cards.

CAMPER NAME: ______________________________ Date of Birth: __________

Church: ______________________________ City, ST: ____________________

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☐ Youth (6th-12th grade) ☐ C1 (09 or 10 grad) ☐ C2 (21-23) ☐ Sr Counselor (24+)

☐ Senior High (6/19-6/25) ☐ Senior High (6/26-7/2) ☐ Junior High (7/4-7/8)

Home Address: ______________________________

City, State and Zip Code: ______________________________

Home Phone: (_______) ____________________ Date of Birth: ____________________

Email Address: ______________________________ ☐ M ☐ F

Custodial Parent/Guardian: ______________________________
Address: (if different)______________________________
Day Phone: (_______) ____________________ Cell Phone: (_______) ____________________

Second Parent or Second Emergency Contact: ______________________________
Relationship: ______________________________
Day Phone: (_______) ____________________ Cell Phone: (_______) ____________________

If not available in an **emergency**, notify:
Name: ______________________________ Relationship: ____________________
Day Phone: (_______) ____________________ Cell Phone: (_______) ____________________

Insurance Information:
Is the participant covered by family medical/hospital insurance? ? ☐ Yes ☐ No
If so, indicate carrier or plan name: ______________________________ Group #

****PHOTOCOPY OF FRONT AND BACK OF YOUR INSURANCE CARD MUST BE ATTACHED.****

Name of family physician: ______________________________ Phone: ____________________
Name of family dentist: ______________________________ Phone: ____________________
Name of specialist: ______________________________ Phone: ____________________

THIS BOX MUST BE COMPLETED FOR CAMP ATTENDANCE:
This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted.
Authorization for Treatment: I hereby give permission to the medical personnel selected by camp authorized staff to order X-rays, routine tests, treatment and necessary transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by camp authorized staff to secure and administer treatment, including hospitalization, for my child as named above. (Please note – Parents will be contacted if the camper has an illness or accident that is of concern to camp authorized staff. Parents will be contacted/ consulted in the event that a trip to Urgent Care, Emergency Room, or other off site medical attention is necessary. In the event that parents cannot be reached, the additional emergency contacts will be called.) I also give permission to the medical personnel to administer over the counter medications as deemed appropriate according to the camper's complaints or condition. The dosage or applications will be directed on the labels of each medication, and may be the generic equivalent. The completed forms may be photocopied in the event of trips out of camp.

Signature of Parent/Guardian or adult camper/staff: ______________________________

Date: ____________________

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PAGE 2 – HEALTH HISTORY – REQUIRED

The following information must be filled in by the parent/guardian or family physician. The intent of this information is to assist us in providing your child the appropriate care. Please keep a copy of this completed form for you records. Any changes to this form should be provided to camp health personnel upon arrival. Provide complete information so that the camp can be aware of your needs. **ALL QUESTIONS AND BLANKS *MUST* BE FILLED IN OR ANSWERED WITH AT LEAST A "YES", "NO" OR "N/A".**

Allergies (List all known) Describe reaction and management of the reaction.

Medication Allergies (list)

_______________ _______________________________
_______________ _______________________________
_______________ _______________________________

Food Allergies (list)

_______________ _______________________________
_______________ _______________________________
_______________ _______________________________

Other Allergies (list, including insect stings, hay fever, asthma, ivy poisoning, animal, etc.)

_______________ _______________________________
_______________ _______________________________
_______________ _______________________________

MEDICATIONS BEING TAKEN Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. ***Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. All medications, including over-the counter/non-prescription, must be turned in to the camp nurse at registration.***

- ☐ This person takes NO medications on a routine basis.
- ☐ This person takes medications as follows:

Med #1: ______________ Dosage: ____________ Specific Time(s) Taken:____________
Reason for taking:____

Med #2: ______________ Dosage: ____________ Specific Time(s) Taken:____________
Reason for taking:____

Med #3: ______________ Dosage: ____________ Specific Time(s) Taken:____________
Reason for taking:____

Attach additional pages, if necessary.

RESTRICTIONS:

Please list any dietary restrictions that may apply to this camper:____________________
____

Please list any restrictions to activities that camp authorized staff need to be aware of:__________
____
____

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MEDICAL HISTORY – CONTINUED

Which of the following has the camper had?

- ☐ Measles
- ☐ Chicken Pox
- ☐ German Measles
- ☐ Mumps
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Rheumatic Fever
- ☐ TB Mantoux Test
  - Date of last test:_________
  - Result: ☐ Positive ☐ Negative

Please give all immunization dates for:

Vaccine	Dates (month & year)
DTP	_____ _____ _____ _____ _____
TD (tetanus and diphtheria) *-or-*	_____ _____ _____ _____ _____
Tetanus	_____ _____ _____ _____ _____
Polio	_____ _____ _____ _____ _____
MMR	_____ _____ _____ _____ _____
or Measles	_____ _____
or Mumps	_____ _____
or Rubella	_____ _____
Influenza B	_____ _____ _____ _____
Hepatitis B	_____ _____ _____
Varicella	_____ _____ (chicken pox)
Other?	_____ _____ _____ (specify:___________________)

General Questions (Explain "yes" answers below.)

Has/Does the participant::	Yes	No
1. Had any recent injury, illness or infectious disease?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐
3. Ever been hospitalized?	☐	☐
4. Ever had surgery?	☐	☐
5. Have frequent headaches?	☐	☐
6. Ever had a head injury?	☐	☐
7. Ever been knocked unconscious?	☐	☐
8. Wear glasses, contacts or protective eyewear?	☐	☐
9. Had frequent ear infections?	☐	☐
10. Ever passed out during or after exercise?	☐	☐
11. Ever been dizzy during or after exercise?	☐	☐
12. Ever had seizures?	☐	☐
13. Ever had chest pain during or after exercise?	☐	☐
14. Ever had high blood pressure?	☐	☐
15. Ever been diagnosed with a heart murmur?	☐	☐
16. Ever had back problems?	☐	☐
17. Ever had problems with joints (knees, ankles, etc.)	☐	☐
18. Have an orthodontic appliance being brought to camp?	☐	☐
19. Have any skin problems (e.g. itching, rashes, acne)	☐	☐
20. Have diabetes?	☐	☐
21. Have asthma?	☐	☐
22. Had mononucleosis in the past 12 mos?	☐	☐
23. Had problems with diarrhea/constipation?	☐	☐
24. Have problems with sleepwalking?	☐	☐
25. If female, has she menstruated?	☐	☐
a.) if no, has she been told about it with instructions?	☐	☐
b.) If yes does she have any abnormal menstrual history?	☐	☐
26. Have a history of bedwetting?	☐	☐
27. Ever have an eating disorder?	☐	☐
28. Ever had emotional difficulties for which professional help was sought?	☐	☐
29. Ever had problems with homesickness?	☐	☐
30. Can the camper swim?	☐	☐

Please explain any "yes" answers, including dates where applicable, noting the numbers of the questions:

____

____

____

____

Use this space to provide any additional information about the camper's behavior and physical, emotional, or mental health about which the camp should be aware.

____

____

____

Camper Complaint	**Medicine Administered** (may be generic equivalent)
Minor aches & pains, headaches, toothaches Or elevated temperature	Motrin or Tylenol
Itching, rash, poison ivy, insect bites or sunburn	Benadryl, Calamine, Aveeno, 1% Hydrocortisone Cream, Technu, Aloe
Mild Diarrhea (w/o other symptoms)	Immodium
Upset Stomach	Tums, Pepto Bismol
Minor Cuts, Scratches, Abrasions	Triple Antibiotic (Neosporin), Sterile Wipes
Mosquito, Insect bites	Insect Repellent, Skeeter Stik, After Bite, Aveeno
Itchy, watery eyes, sneezing, runny nose	Benadryl tablet, Claritin
Stuffy Nose	Sudafed
Sore Throat	Throat Lozenges or Spray, Chloraseptic/equivalent
Sun Exposure	Aloe Vera, Sunscreen

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