

# THIELTGES ST. THOMAS SUMMER CAMP HEALTH & MEDICAL SUMMARY

The information on this form is not part of the camper acceptance process, but is gathered to assist us in identifying appropriate care.  
**THIS FORM MUST BE FILLED OUT BY THE CUSTODIAL PARENT/GUARDIAN.**

Camper's first time at camp?  YES  NO

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age at camp \_\_\_\_\_  
*Last First Middle*

Home Address \_\_\_\_\_  
*Street Address City State Zip*

Gender  Male  Female Dates of Desired Camp Attendance \_\_\_\_\_

Custodial parent/guardian \_\_\_\_\_

Home Address \_\_\_\_\_  
*(if different from above) Street Address City State Zip*

Contact Phone Numbers \_\_\_\_\_  
*Home Business Cell*

Second parent or guardian or emergency contact \_\_\_\_\_

Home Address \_\_\_\_\_  
*Street Address City State Zip*

Contact Phone Numbers \_\_\_\_\_  
*Home Business Cell*

If not available in an emergency, notify:

Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Home Address \_\_\_\_\_  
*Street Address City State Zip*

## 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 HEALTH INSURANCE CARD MUST BE ATTACHED TO THIS FORM.**

## Important – The following boxes must be complete for attendance.

**Parent/Guardian Authorizations:** This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide routine health care, administer prescribed medications and seek medical treatment including ordering x-rays for routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for my child.

I hereby grant permission to Thieltges St. Thomas Camp staff, as "personal representative" of my child while enrolled at camp, to receive any records or results of medical treatment given to my child while enrolled at Thieltges St. Thomas Camp.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age at camp \_\_\_\_\_  
*Last First Middle*

**Healthcare Notification Policy:** Our staff will make every effort to contact you by phone, using the phone numbers provided on your child’s health form, if your child has need for out-of-camp healthcare. Because of timing and scheduling conflicts, we cannot promise that we will be successful in reaching you. Please make sure that we know how to reach you during your child’s stay. In addition to phone contact, we will provide you with a written summary about out-of-camp healthcare given to your child, as well as for sickness or injuries sustained by your child which might require post-camp observation or treatment. We generally do not contact you if your child is seen in the camp for routine problems (e.g. skinned knees, sore throat, headache) that do not require physician referral. The decision to consult you for routine, in-camp healthcare is determined on a case-by-case basis. You will typically be notified if your child needs care for a repeated complaint, or if your child’s condition does not improve in a reasonable amount of time.

**Please check one of the following, and sign below:**

- I understand and agree to the “Healthcare Notification Policy” enumerated above:
- OR
- I wish to be contacted before the camp staff administers any medical care (other the emergency care) to my child:

Signature of parent/guardian \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_

**Over-the-counter Medications:** I (parent/guardian) hereby give permission to Thieltes St. Thomas Camp to administer to my child the following over-the-counter medications, if the camp staff deems it necessary. Dosages will be administered according to directions on the bottle, unless directed otherwise.

- \*Acetaminophen (such as Tylenol) for mild burns (incl. sunburn) , sprains, fever, headache, or menstrual cramps
- \*Ibuprofen for sprains or menstrual cramps \*Midol for menstrual cramps \* Antiseptic first aid spray w/benzocaine (such as Solarcaine) for sunburn or insect bites
- \* Diphenhydramine (such as Benadryl) for contact dermatitis (such as poison ivy) or insect bites
- \* Zinc/ferric oxide lotion (such as Calamine) or hydrocortisone cream for contact dermatitis or insect bites \* Pseudoephedrine for colds
- \* Topical antibiotic ointment (such as Bacitracin or Polysporin) for tick bites, skin infections, lacerations, or abrasions
- \* Throat lozenges for sore throat \* Chewable calcium antacid (such as Tums) for a stomach ache \* Kopectate, Imodium A-D, or equivalent for diarrhea

Signature of parent/guardian \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_

**Health History**

The following information must be filled in by the parent/guardian. The intent of this information is to provide background information in order to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to the camp staff upon participant’s arrival in camp. Provide complete information so that the camp can be aware of your camper’s needs.

**ALLERGIES (list all known)** Describe reaction and management of the reaction.

**Medication allergies (list)**


**Food allergies (list)**


Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age at camp \_\_\_\_\_  
*Last First Middle*

**Other allergies** (list) – include insect stings, hay fever, asthma, animal dander, 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.

\_\_\_\_ This person takes NO medications on a routine basis.

\_\_\_\_ This person takes medications as follows:

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

Med #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer: \_\_\_\_\_  
\_\_\_\_\_

### RESTRICTIONS

The following restrictions apply to this individual.

#### Dietary

\_\_\_\_ Does not eat red meat      \_\_\_\_ Does not eat pork      \_\_\_\_ Does not eat eggs

\_\_\_\_ Does not eat poultry      \_\_\_\_ Does not eat seafood      \_\_\_\_ Does not eat dairy products

\_\_\_\_ Other (describe) \_\_\_\_\_  
\_\_\_\_\_

**Explain any restrictions to activity** (e.g. what cannot be done, what adaptations or limitations are necessary)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age at camp \_\_\_\_\_  
*Last First Middle*

**Other** (list any current medical health concerns we should be aware of and not listed above (e.g. participant's behavior and physical, emotional, or mental health))

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I understand and agree to abide by any restrictions placed on my participation in camp activities:

**Signature of Camper** \_\_\_\_\_ **Date** \_\_\_\_\_

I have read and filled out this form and affirm all information is accurate and complete.

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_