

# Mt. Hood Kiwanis Camp Health History and Examination Form

Please give complete information below so the camp is aware of your camper's needs and has the information necessary for appropriate care. If there are changes after you send us the form, please notify the nurse upon arrival at camp.

**Camper Last Name** \_\_\_\_\_ **First** \_\_\_\_\_ **Nickname** \_\_\_\_\_

Birth date \_\_\_\_\_ Age at camp \_\_\_\_\_ Social Security # \_\_\_\_\_ [ ] Male [ ] Female

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

Home address \_\_\_\_\_ City, State, Zip \_\_\_\_\_ Home phone \_\_\_\_\_

Business address \_\_\_\_\_ City, State, Zip \_\_\_\_\_ Business phone \_\_\_\_\_

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

Home address \_\_\_\_\_ City, State, Zip \_\_\_\_\_ Home phone \_\_\_\_\_

Business address \_\_\_\_\_ City, State, Zip \_\_\_\_\_ Business phone \_\_\_\_\_

Group home name \_\_\_\_\_ Manager \_\_\_\_\_ Phone \_\_\_\_\_

**If above persons are not available in an emergency, notify:**

Full name \_\_\_\_\_ Relationship to camper \_\_\_\_\_ Business phone \_\_\_\_\_

Address \_\_\_\_\_ Home phone \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Dentist/Orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Is the camper covered by medical/hospital insurance? [ ] Yes [ ] No

If yes, give carrier or plan name \_\_\_\_\_ Policy/Group # \_\_\_\_\_

Name of insured/relationship to camper \_\_\_\_\_ Insurance ID # \_\_\_\_\_

## **AN IMPORTANT MESSAGE REGARDING MEDICATION WHILE AT CAMP**

**PLEASE READ THIS MESSAGE EVEN IF YOUR CHILD DOES NOT TAKE ANY PRESCRIBED MEDICATION. POLICIES REGARDING THE ADMINISTERING OF NON-PRESCRIBED MEDICATION AS WELL.**

Dear Parents/Caregivers-

This letter is designed to give you information regarding the administration of medication at Mt. Hood Kiwanis Camp. A registered nurse will administer all medications at Camp. During check-in **YOU MUST WAIT IN LINE AND GIVE MEDICATION DIRECTLY TO THE NURSE.** During this check-in you will be able to discuss any medical questions you may have and to give any special instructions about the administration of medicine to your camper. An individual medical log sheet will be completed for any medication provided. You will be asked to review and initial this log sheet with the nurse. The following guidelines have been established to ensure the safe and proper administration of medicine.

**IF YOU ARE BRINGING YOUR OWN MEDICATION:**

**1. Each medication, including over-the counter medication and vitamins must be in its original container with the proper label.**

**2. For prescription medications, the prescription must be current (within 1 year), in the camper's name and with the proper instructions. If the instructions/dosages have changed, you must provide a doctor's note stating the new instructions/dosages.**

3. Please send extra pills/liquid medication in the event that medication is dropped or spit out and becomes unfit for administration.

4. If your camper needs special equipment (e.g. a certain cup or straw) or food other than applesauce (e.g. pudding or yogurt) to take medication, please bring these to camp in the original container, labeled with camper's name.

**PLEASE NOTE THAT ITEMS 1 & 2 MUST BE MET IN**

**ORDER FOR YOUR CAMPER TO ATTEND CAMP!**

**OVER THE COUNTER MEDICATION ADMINISTRATION**

In addition to the medications you provide for your camper, Camp nurses have standing orders to administer certain over-the-counter-medications. These medications are listed on page 5 for your review. There are two options that you may choose from. You may change this choice at any time.

Please complete ONE of the two options. In most cases the nurse will not call when these medications are given. However, you would be notified right away if your camper is seriously ill or does not respond to over the counter medication. The administration of these medications is documented in the Camp treatment log. Complete option 2 on the reverse side if you would like to be notified prior to the administration of these medications. Please note that this option may cause a delay in your camper's symptoms if you are not readily available.

**This Box Must be Complete for Attendance**

**Parent/Guardian Authorizations:** This health history on both pages is correct and complete to the best of my knowledge. 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 emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any record necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for this participant. 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 participant. I also agree to be responsible for any expenses which may be incurred in providing emergency medical or surgical treatment to this participant. This completed form may be photocopied for trips out of camp.

**Signature of parent/guardian or adult camper** \_\_\_\_\_

**Printed name** \_\_\_\_\_

**Date** \_\_\_\_\_

**Camper's Name:** \_\_\_\_\_

Have/has the camper:		Yes	No			Yes	No
1	Recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	12	Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>
2	Have a chronic or recurring illness?	<input type="checkbox"/>	<input type="checkbox"/>	13	Been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
3	Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	14	Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
4	Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	15	Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
5	Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	16	Ever had problems with joints	<input type="checkbox"/>	<input type="checkbox"/>
6	Had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	17	Have any skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
7	Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	18	Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
8	Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	19	Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
9	Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	20	Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
10	Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	21	If female, abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
11	Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	22	Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
				23	Required psychiatric treatment?	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any 'yes' answers, noting the number of the questions: \_\_\_\_\_

Attach additional pages if necessary

**Allergies:** List all known allergies. Describe reaction and management of the reaction. Attach additional page if necessary.

Medication allergies: \_\_\_\_\_

Other allergies (include insect stings, hay fever, asthma, animal dander, etc.): \_\_\_\_\_

Food allergies: \_\_\_\_\_

Will this camper need a special diet? If so, please provide all necessary food for this camper for the week. IE Gluten and Casein free diets

**Medications Being Taken:** List ALL medications including over-the-counter or non-prescription drugs taken routinely. Bring enough 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 list will aid the health care staff at camp, so while we realize that these might change please fill out entirely.

This person takes **NO** medications on a routine basis.

Name of Prescription	Dosage	Time Given

Name of PRN (as needed)	Dosage	Reason for Medication

Name of Vitamin/Supplement	Dosage	Time

**Camper's Name:** \_\_\_\_\_

**Immunizations**, please attach sheet if necessary

Check if participant has had:

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Date of last TB Mantoux Test \_\_\_\_\_
- Result:  Positive  Negative

Please give all dates of immunizations (write 'none' if not immunized):

Vaccine	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		_____	_____	_____	_____	_____
TD (tetanus/diphtheria)		_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____
MMR		_____	_____	_____	_____	_____
or Measles		_____	_____	_____	_____	_____
or Mumps		_____	_____	_____	_____	_____
or Rubella		_____	_____	_____	_____	_____
Haemophilus influenza B		_____	_____	_____	_____	_____
Hepatitis A		_____	_____	_____	_____	_____
Hepatitis B		_____	_____	_____	_____	_____
Varicella (chicken pox)		_____	_____	_____	_____	_____
BCG		_____	_____	_____	_____	_____

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**To Be Completed by Licensed Health Care Provider**

**I have examined the above-named camp participant within two years prior to camp attendance. Date examined: \_\_\_\_\_**

In my opinion, the above applicant  is  is not able to participate in an active camp program.

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Diagnoses \_\_\_\_\_

The participant is under the care of a physician for the following conditions: \_\_\_\_\_

Recommendations and Restrictions while at Mt. Hood Kiwanis Camp

Treatment to be continued at camp \_\_\_\_\_

Medications to be administered at camp (name, dosage, frequency) \_\_\_\_\_

Any medically prescribed dietary restrictions \_\_\_\_\_

Known allergies \_\_\_\_\_

Describe any limitation or restriction on camp activities \_\_\_\_\_

Does this person have a positive diagnostic x-ray for Atlantoaxial Dislocation Condition? \_\_\_\_ If yes, give activity restrictions relating to horseback riding adventure course, etc. \_\_\_\_\_

***Please attach additional information that may assist health care staff at camp.***

**Signature of Health Care Provider** \_\_\_\_\_ **Date** \_\_\_\_\_

Printed Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**Please send to Mt. Hood Kiwanis Camp Office, 9320 SW Barbur Blvd. Suite 165, Portland OR 97219-5430**

**Camper's Name:** \_\_\_\_\_

**Camp Physician Standing Orders**

At times, it maybe become necessary to treat minor ailments from our Camp Physician Standing orders. The following medications may be used. Please indicate whether these medications are acceptable to give your camper under the direction of the Mt. Hood Kiwanis Camp Standing Orders.

<b>MEDICATION</b>	<b>YES</b>	<b>NO</b>
Benadryl or Generic Equivalent (for allergic reactions and sleep)		
Aloe Vera Gel		
Antibiotic Ointment (e.g. Neosporin)		
Calamine Lotion/Caladryl		
Cough Syrup		
NyQuil (over 12 years old only)		
DayQuil (over 12 years old only)		
Cough Drops		
Dulcolax tabs (for constipation)		
Glycerin or Dulcolax suppository (for constipation)		
Epinephrine (for serious allergic reaction)		
Fleet Enema		
Head Lice Shampoo		
Hydrocortisone Cream 1%		
Advil/Ibuprofen		
Tylenol or Generic Equivalent		
Ematrol or Generic Equivalent (for nausea)		
Sarna Lotion		
Motrin or Generic Equivalent		
Midol or Generic Equivalent (for menstrual cramps)		
Ivy Dry/Ivy Stat or Generic Equivalent (for poison oak)		
Kaopectate		
Milk of Magnesia		
Pepto Bismo (for upset stomach, nausea, or diarrhea)		
Rash Ointments (e.g. Destin)		
Solarcaine		
Saline-for eyes		
Swimmer's Ear or Generic Equivalent- water drying drops		
Sunblock		
Auralgen ear drops (earache)		
Bug Spray		
Aspirin		
Tums		

I authorize the Mt. Hood Kiwanis Camp to administer the medications listed on the Camper Medication Record page according to the manufacturers' written instructions. The medication information given today supersedes any previous information given at the time of registration.

I authorize the Mt. Hood Kiwanis Camp to administer any of the above medications indicated "yes" according to the Camp Standing Orders, as necessary for minor ailments.

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

Camper's Name: \_\_\_\_\_

## ACCEPTANCE CRITERIA AND AGREEMENT

Please read and sign this page

Mt. Hood Kiwanis Camp, Inc. accepts applicants regardless of race, color, national origin, sex, sexual orientation, veteran status or disability. The following criteria are used to determine acceptance: The applicant (1) must be able to benefit from the camp program, (2) must be adaptable to the group living environment, (3) must not be physically, verbally, or sexually abusive, (4) must have no history of arson or fire setting AND (5) must be free of conditions and behaviors that might not be manageable in a camp setting. (See Program Eligibility Standards)

We (camper and parent/guardian) wish the applicant who signs below to participate in the Mt. Hood Kiwanis Camp program. We recognize that there may be risk of injury during such participation and that certain dangers and accidents may occur. We further agree that each person participating in the program must follow safety instructions, remain in areas designated by staff, and refrain from behavior that is harmful to himself/herself or others. Failure to do so will be cause for the camper's dismissal from the program. Please be aware that all of Mt. Hood Kiwanis Camp's employees and volunteers are mandatory reporters. Any concerns or allegations of abuse will be reported directly to Department of Human Services and not to the parents or caregivers of the camper.

In consideration of participation in the program, the camper and the camper's parents hereby release and discharge the Mt. Hood Kiwanis Camp, Inc., its officers, agents and employees; Kiwanis Clubs and their members; Portland State University, its employees and students; the State of Oregon; the U.S. Forest Service and the agents and insurers of each of them, from any and all claims, arising from negligence including but not to exceed ordinary negligence as allowed by Oregon state law, or breach of contract, because of any injury to the applicant during participation in the program. Further, we agree to defend and indemnify the Camp, its officers, agents and employees; Kiwanis Clubs and their members; Portland State University, its employees and students; the State of Oregon; the U.S. Forest Service and the agents and insurers of each of them, from actions for damages or expense caused to other participants in the program which are caused by our camper.

I give permission for the Camp Director or his/her designee to search camper's belongings, with camper present, when the health, well-being or safety of the camper or others requires a search.

I give permission for camper to be transported in camp-designated vehicles for off-site trips and for emergency or routine medical care.

I understand that the Mt. Hood Kiwanis Camp must provide a safe and cooperative group experience for all campers and that the applicant may be dismissed from the program for reasons including behavior, illness, injury or homesickness.

I understand that any refund for a camper leaving the camp early will be prorated based on the number of nights spent at camp.

I have read and understand the fee structure, refund and balance-due policies and agree to pay as stated.

I do \_\_\_\_ do not \_\_\_\_ give my permission for my camper to call me collect from camp.

I understand that photographs may be taken at the camp showing the campers and camp staff in their usual camp activities. Some photographs will be used by Mt. Hood Kiwanis Camp and Portland State University for both promotional and educational purposes in printed materials, on our website and in other media. I also understand that other parents, guests, staff, and volunteers will be taking pictures as well and it is out of Mt. Hood Kiwanis Camp's control to monitor the use of these pictures.

**Yes**, I agree that Mt. Hood Kiwanis Camp, Inc. and Portland State University may take photographs of campers in usual camp activities and that the pictures may be used for the above purposes as deemed proper by Mt. Hood Kiwanis Camp, Inc. and/or Portland State University.

**Initial here if you give permission:** \_\_\_\_\_

**No**. I do not give permission for Mt. Hood Kiwanis Camp, Inc. and Portland State University to use photographs of the camper for promotional or educational purposes.

**Initial here if you do NOT give permission:** \_\_\_\_\_

I DO HEREBY ACKNOWLEDGE that I have carefully read all of the foregoing information and I understand and agree to its contents.

x \_\_\_\_\_

Signature of Parent or Guardian

\_\_\_\_\_

Date

I understand and agree to follow the policies of the Mt. Hood Kiwanis Camp and any restrictions placed on my camp activities.

x \_\_\_\_\_

Signature of Camper

\_\_\_\_\_

Date