Camp Fire
Camp Toccoa

Summer 2018
Camper Health Packet

Dear Parent/Guardian,

We look forward to getting to know you better and working with you to ensure your camper has a safe and successful stay at Camp Fire Camp Toccoa. Please review all documents included within this packet. **The medical form must be signed and returned three (3) weeks prior to the camper's stay.** The medical form requires a signature by a licensed medical care provider. All campers must have a new medical form each year**.** Include a copy of the campers insurance card (front and back) along with a current immunization record.

NEW THIS YEAR!
If your camper will be taking medication while at Camp Fire Camp Toccoa, over the counter or prescribed, a Medication Administration Record (included in this packet) must be completed and returned for EACH SESSION the camper is attending. (IE: If you camper is attending 2 sessions, you must complete 2 forms). If your camper has an epi pen or inhaler please complete the Epi Pen/Inhaler section.

Prescription medication must be sent in the original container containing only the dosage required for your campers stay. Controlled substances will be counted by the nursing staff or camp director at check in. Do not send over the counter medication or vitamins with the exception of Melatonin or daily allergy medication which must be in the original container and only containing the required dosage for the campers stay.

Camp Fire Camp Toccoa cannot accept medication that is not in the original prescription contain, any amount over the exact dosage for the campers stay, over the counter medication that is not Melatonin or daily allergy medication, or any medication that is not accompanied by the Medication Administration Record. Medication, prescribed or over the counter are not to be stored in camper's luggage. If medication, vitamins etc. is found in your camper's luggage, the parent/guardian will be notified and the medication will not be administered to the camper.

Forms can be mailed to:
Camp Fire Camp Toccoa / Medical Form
92 Camp Toccoa Drive
Toccoa, GA 30455

Fax: (706) 886-5123
Email: camptoccoamedicalforms@gmail.com

Thank you, Camp Fire Camp Toccoa Staff

Camp Fire
Light the fire within

Camp Fire Georgia / Camp Fire Camp Toccoa
Camper Medical and Health History

Attending Camp Session(s)

1 2 3 4 5 6 7

CIT LIT Staff

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to the camp health personnel upon the participant's arrival at camp. Provide complete information so that the camp can be aware of your camper's needs.

A NEW MEDICAL FORM IS REQUIRED EACH YEAR.
PAGE 5 MUST BE COMPLETED BY A LICENSED MEDICAL PROVIDER

Last Name: _____

First Name: _____

PARTICIPANT INFORMATION

Please Print

Participant Name: _____
Last First Middle

Home Address: _____
Street Address City State Zip

Birth Date _____/____/_____ Age at Camp_____ Gender: Male Female

Parent/Guardian Name: _____ Phone: _____

Home Address: _____
(If different from above) Street Address City State Zip

Second Parent/Guardian Name: _____ Phone: _____

If neither parent/guardian is available in emergency, notify:_____

Relationship to camper: _____ Phone: _____

Home Address: _____
Street Address City State Zip

2nd Emergency Contact: _____

Relationship to camper: _____ Phone: _____

Home Address: _____
Street Address City State Zip

INSURANCE INFORMATION

Is the participant covered by family medical/hospital insurance? Yes ☐ No ☐
If yes, please indicate carrier or plan name: _____ Group # _____
Date of birth of the primary card holder: _____/_____/_____

A photo copy of the front and back of the health insurance card must be attached to this form.

Camp Fire
92 Camp Toccoa Drive Toccoa, GA 30577
Office (706) 886-2457 Fax (706) 886-5123

ALLERGIES (lists all known allergies, attach additional sheet if needed)

Allergies	Type of reaction	Estimated Date of last reaction
_____	_____	_____
_____	_____	_____
_____	_____	_____

Last Name: _____

First Name: _____

MEDICATIONS BEING TAKEN

List **ALL** medications (including over-the-counter) or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. All medication must be in the original packing/bottle that identifies the prescribing physician, the name of the medication, the dosage and the frequency of administration.

This person takes NO medication on a routine basis OR this person takes medications as follows:

Medication #1 _____ Dosage _____ Time of day taken _____
Reason for taking: _____

Medication #2 _____ Dosage _____ Time of day taken _____
Reason for taking: _____

Medication #3 _____ Dosage _____ Time of day taken _____
Reason for taking: _____

Medication #4 _____ Dosage _____ Time of day taken _____
Reason for taking: _____

Attach additional pages for more medications. Also, please identify any medications taken during the school year that the participant does not need at camp _____

The following non-prescription medications are available to be given by the camp nurse and are used on an as needed basis to manage illness and injury.

Circle medications that are *okay* to give to the camper

Acetaminophen (Tylenol)	Ibuprofen	Cough medication
Benadryl	Cough drops	Calamine lotion
Hydrocortisone cream	Topical antibiotic cream	Anti-nausea
Solarcaine (Aloe)	Bismuth subsalicylate (Pepto-Bismo)	

RESTRICTIONS (The following restrictions apply to this individual)

Does not eat: ☐ Red Meat ☐ Pork ☐ Dairy Products ☐ Poultry
☐ Seafood ☐ Egg Other _____ _____

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GENERAL QUESTIONS:

Has/does the participant:	Yes	No
Had any recent injury, illness or infectious disease?		
Have a chronic or recurring illness/condition?		
Ever been hospitalized?		
Ever had surgery?		
Have frequent headaches?		
Ever had a head injury?		
Ever been knocked unconscious?		
Wear glasses, contacts or protective lenses?		
Ever had frequent ear infections?		
Ever passed out during or after exercise?		
Ever been dizzy during or after exercise?		
Ever had seizures?		
Ever had chest pains during or after exercise?		
Ever had high blood pressure?		
Ever been diagnosed with a heart murmur?		
Ever had problems with joints (e.g. knees)?		

	Yes	No
Ever had back problems?		
Have ear tubes?		
Have an orthodontic appliance at camp?		
Have any skin problems? (e.g. itching, rash?)		
Have diabetes?		
Have asthma?		
Had mononucleosis in the last 12 months?		
Had problems with diarrhea/constipation?		
Have problems with sleep walking?		
If female, have abnormal menstrual history?		
Have a history of bed wetting?		
Ever had an eating disorder?		
Ever had emotional difficulties in which professional help was sought?		
Had a significant life event that continues to after the camper's life? Abuse, death, divorce, etc..		

Please explain "yes" answers: _____

_____

_____

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

_____

_____

_____

_____

IMMUNIZATIONS:

Which of the following has the camper had?

____ Measles
____ Chicken Pox
____ German measles
____ Mumps
____ Hepatitis A
____ Hepatitis B
____ Hepatitis C

TB Mantoux test
Date of last test: _____
Result: ___ Positive ____ Negative

Please give dates of all immunizations:

Vaccine	M/Y	M/Y	M/Y	M/Y	M/Y	M/Y
DTP						
TD Tetanus/diphtheria						
Tetanus						
Polio					X	X
MMR			X	X	X	X
Or Measles			X	X	X	X
Or Mumps			X	X	X	X
Or Rubella			X	X	X	X
Hemphilus influenza B					X	X
Hepatitis B				X	X	X
Varicella (chicken pox)			X	X	X	X

If your 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 parent or guardian: _____ Date: _____

Last Name: _____

First Name: _____

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HEALTH CARE PROVIDERS:

Name of camper's primary doctor: _____ Phone: _____

Name of camper's dentist: _____ Phone: _____

Name of camper's orthodontist: _____ Phone:_____

Have we forgotten anything? In the space below please provide any additional information about the camper's health you think is important or that may affect the camper's ability to fully participate in the camp program.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

First Name: _____ Last Name: _____

PARENT/GUARDIAN AUTHORIZATIONS:

This health history is correct and complete as far as I know, and 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 x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. 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. The completed form may be photocopied for trips out of camp.

Signature of parent or guardian: _____

Printed name _____ Date_____

Camp Fire
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Office (706) 886-2457 Fax (706) 886-5123

Camp Fire Georgia / Camp Fire Camp Toccoa
Camper Medical and Health History

Participant Name: _____
Last First Middle

Home Address: _____
Street Address City State Zip

Birth Date _____/____/_____ Age at Camp_____ Gender: Male Female

Physical exam done today: _____ Yes _____ No If no, date of last physical: _____
Month/Day/Year

A physical exam must have been performed within the last 12 months.

Weight _____ lbs Height _____ ft _____ in Blood Pressure _____/_____

ALLERGIES _____ **No known allergies**

To foods (list): _____
To medications (list):_____
To the environment (insect stings, etc):_____
Other allergies (list):_____
Describe previous reaction:

DIETARY RESTRICTIONS (The following restrictions apply to this individual)

Does not eat: ☐ Red Meat ☐ Pork ☐ Dairy Products ☐ Poultry
☐ Seafood ☐ Egg Other _____

The camper is undergoing treatment at this time for the following conditions: (describe below)

MEDICATION _____ **No medications take daily** _____ **will take the following prescribed medications while at camp**

Medication #1 _____ Dosage _____ Time of day taken _____
Reason for taking: _____

Medication #2 _____ Dosage _____ Time of day taken _____
Reason for taking: _____

Medication #3 _____ Dosage _____ Time of day taken _____
Reason for taking: _____

Attach additional pages for more medications. Also, please identify any medications taken during the school year that the participant does not need at camp _____.

Do you feel that the camper will require limitations or restrictions to activity while at camp? _____ Yes _____ No
If you answered "yes" to the questions above, what do you recommend? Describe below, attach additional sheet if needed.

"I have reviewed the Camper Medical and Health History form, and have discussed the camp program with the campers parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)"

Name of licensed medical provider (please print): _____
Signature: _____ Title:_____
Office Address:_____
Telephone: _____ Date:_____

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Camp Fire
Camp Toccoa

Camper Name: _____
Unit: _____ Cabin #: _____
Counselor: _____
Session #_____

Contemplate this portion if your camper has an Epi Pen/ Inhaler

Circle One: **Epi Pen (Allergy to: _____)**

Inhaler

We request that the child named above be permitted to (option 1) carry his/her own Epi Pen/Inhaler, (option 2) have the medication kept by his/hers counselor, (option 3) or store the medication in the onsite under the supervision of the camp medical designee.

I direct my child's medication to be stored: _____.
CHOOSE ONE OF THE OPTIONS FROM THE ABOVE PARAGRAPH

If you choose to permit your child to carry his/her medication you are agreeing that he/she has been instructed in the proper procedure of self-administration and is capable of carrying his/her own properly labeled Epi Pen / Inhaler in the original container. He/she understands the purpose, proper method, and the frequency of the use of this medication as prescribed my child's physician.

Parent/Guardian Signature: _____ Date: _____

Complete this portion (next page) if your camper will be taking ANY medication while at Camp Fire Camp Toccoa.

If your camper will be taking medication while at Camp Fire Camp Toccoa, over the counter or prescribed, the Medication Administration Record (next page) must be completed and returned for EACH SESSION the camper is attending.

Prescription medication must be sent in the original container containing only the dosage required for your campers stay. Controlled substances will be counted by the nursing staff or camp director at check in. Do not send over the counter medication or vitamins with the exception of Melatonin or daily allergy medication which must be in the original container and only containing the required dosage for the campers stay. Camp Fire Camp Toccoa cannot accept medication that is not in the original prescription contain, any amount over the exact dosage for the campers stay, over the counter medication that is not Melatonin or daily allergy medication, or any medication that is not accompanied by the Medication Administration Record. Medication, prescribed or over the counter are not to be stored in camper's luggage. If medication, vitamins etc. is found in your camper's luggage, the parent/guardian will be notified and the medication will not be administered to the camper.

On the table below please list your child's medication by name (using the name on the prescription), and the required dosage. Note that Camp Fire Camp Toccoa personnel can only administer the dosage as prescribed on the bottle. If your camper take the same medication multiple times a day it must be written in each time slot.

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Camp Fire
Camp Toccoa

Camper Name: _____
Unit: _____ Cabin #: _____
Counselor: _____
Session #_____

Camper Medication Administration Record

Medication will not be dispensed on the day/times of the grayed out boxes UNLESS your child is staying for changeover!

Breakfast Medication

Name of Medication / Dosage	Time Dispensed	Sun	Mon	Tue	Wed	Thurs	Fri	Sat
	BREAKFAST							
	BREAKFAST							
	BREAKFAST							
	BREAKFAST							

Lunch Medication

Name of Medication / Dosage	Time Dispensed	Sun	Mon	Tue	Wed	Thurs	Fri	Sat
	LUNCH							
	LUNCH							

Dinner Medication

Name of Medication / Dosage	Time Dispensed	Sun	Mon	Tue	Wed	Thurs	Fri	Sat
	DINNER							
	DINNER							
	DINNER							
	DINNER							

Bedtime Medication

Name of Medication / Dosage	Time dispensed	Sun	Mon	Tue	Wed	Thurs	Fri	Sat
	BEDTIME							
	BEDTIME							
	BEDTIME							
	BEDTIME							

Additional Comments: _____

_____

_____

Parent/Guardia Signature: _____ **Date:** _____

For Staff Use Only

Control Substance	Count In	Parent/ Guardian Initials	Staff Initials	Count Out	Nurse	Camp Director

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