

# 2009 SPIRIT in the PINES Camper Health Evaluation Form

This Health Evaluation Form is **required** for each camper and must be turned in to the Camp Registrar **by May 15**. Please fill this form out completely including the "Consent for Non-Prescription Medications" and sign it. **A physical examination is required every 2 years. If your last physical was before June 1, 2007, you must see your doctor prior to attending camp.** A copy of the examination does not need to be included with this form. **A current copy of your child's Immunization Record must be attached.**

DATE OF CAMP WEEK \_\_\_\_\_

Camper's Full Name \_\_\_\_\_ M or F Age \_\_\_\_\_ Birth Date \_\_\_\_\_  
(Circle one)

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Phone (H) \_\_\_\_\_ Work/Cell \_\_\_\_\_  
(Circle one)

Second Parent/Guardian \_\_\_\_\_ Phone (H) \_\_\_\_\_ Work/Cell \_\_\_\_\_  
(Circle one)

Emergency Contact Person \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Clinic Name \_\_\_\_\_ Phone \_\_\_\_\_

## Health Insurance Information

Insurance Carrier \_\_\_\_\_ Group # \_\_\_\_\_

Carrier Address \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ ID # \_\_\_\_\_

Birth date of Policy Holder \_\_\_\_\_ *please attach copy of insurance card*

**IMPORTANT: IN CASE OF MEDICAL EMERGENCY**, I understand that the camp staff will attempt to contact me or my Emergency Contact Person. In the event that I or my Emergency Contact Person cannot be reached, I give permission to the Physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child, as named above. I understand that I am fully responsible for all payments incurred for such treatment. I also understand that Medical and Hospital insurance is not provided by St. Andrew Lutheran Church or SPIRIT in the PINES Camp. All information on this Health Evaluation Form is accurate and true to the best of my knowledge.

Activities at Spirit in the Pines may include, but are not limited to active outdoor games, swimming, floating raft, canoeing, boating, group building course, and off-site activities. All activities are staffed and supervised to ensure safety. I understand the risks involved in such activities, and give permission for my child to participate in all activities.

I also give permission for my child's picture to be taken at camp and used for promotional/keepsake purposes. I understand that my child's name will not be used in conjunction with the photo.

**SIGNED** \_\_\_\_\_ **DATE** \_\_\_\_\_

Parent or Guardian

(Over)

Date of Last Physical Examination \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
(For medication dosage purposes)

- 1) Does the camper have any allergies? Yes No  
(Circle one)

Please list if "Yes" \_\_\_\_\_

*if food allergy is listed, please complete the Food Allergy Questionnaire and attach to this form*

- 2) Has the camper recently been exposed to any contagious diseases? Yes No  
(Circle one)

Please list details if "Yes" \_\_\_\_\_

**PLEASE DO NOT SEND YOUR CHILD TO CAMP IF HE/SHE IS ILL.**

- 3) Is the camper taking any medication which must be continued at camp? Yes No  
(Circle one)

If "Yes", list medication(s) \_\_\_\_\_

(Attach a separate sheet if necessary)

**The medication must be clearly marked with the camper's name and dose instructions in the original container. Any change to original instructions requires a signed note from the parent/guardian stating those changes. The camp health professional or camp director will dispense all medication.**

*For the safety of all Campers, Counselors and CIT's, and in accordance with Minnesota Department of Health Guidelines, medication must not be packed in luggage. All medications must be turned in at the check-in table at St. Andrew before departing for camp. It is not necessary to bring over-the-counter medications, as they are available at the camp Health Office. (See list of available medications below.)*

- 6) Are there any health restrictions on the camper's activity? Yes No  
(Circle one)

Please state details if "Yes" \_\_\_\_\_

- 7) Are there any health restrictions on the camper's diet? Yes No  
(Circle one)

Please state details if "Yes" \_\_\_\_\_

- 8) Does the camper have any medical/behavioral/social problems the camp should be informed of? Yes No  
(Circle one)

Please list details if "Yes" \_\_\_\_\_

**If Asthma is listed, please complete the "Asthma History and Treatment" form and attach it to this form.**

- 9) Other information helpful to camp staff \_\_\_\_\_

### **Consent for Non-Prescription Medication**

**I hereby give SPIRIT in the PINES Camp permission to administer any of the following over-the-counter medication(s) that are checked. Medications will be dispensed in accordance with the directions for age appropriate use on the container. Please check all that apply.**

_____ Acetaminophen (Tylenol)	_____ Ibuprofen (Advil)	_____ Sunscreen
_____ Cold Medication (antihistamine/decongestant)	_____ Cough Suppressant	_____ Cough Lozenges
_____ Tums	_____ Pepto-Bismol	_____ Imodium A-D
_____ Eye Drops	_____ Ear Drops	_____ Insect Repellent
_____ Benadryl	_____ Topical Itch Cream (Hydrocortisone)	_____ Poison Ivy Cream

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

**Remember to attach a current copy of your child's Immunization Record  
AND a copy of the Health Insurance Card, both sides.**

# CABINMATE REQUEST CARD

Your Name \_\_\_\_\_ Camp Date \_\_\_\_\_

*Every camper must complete a Cabinmate Request Card. Remember that camp is about making new friends and meeting new people!*

We guarantee your first choice if the person you have chosen as your first choice lists you as their first choice. We will also make every effort to honor your second choice (if you have one).

**EVERYONE** please return this card to the camp office at St. Andrew Church at least three weeks before your week of camp. All late arriving cards will be processed to the best of our ability, but with no guarantees.

1<sup>st</sup> Choice \_\_\_\_\_

2<sup>nd</sup> Choice (optional) \_\_\_\_\_

***\*\*Put me with anyone!\_\_\_\_\_***

# ASTHMA HISTORY & TREATMENT FORM

SPIRIT in the PINES Camp

Child's Name \_\_\_\_\_ Date \_\_\_\_\_

Parent's Name \_\_\_\_\_ Phone (H) \_\_\_\_\_

Address \_\_\_\_\_ Phone (W) \_\_\_\_\_

Physician treating child's asthma \_\_\_\_\_ Phone \_\_\_\_\_

1. How long has your child had asthma? \_\_\_\_\_

2. Please rate the severity of his/her asthma. (circle one)

(Not severe) 1    2    3    4    5    6    7    8    9    10    (Severe)

3. What triggers your child's asthma attacks? (Please check any that apply and describe as fully as possible.)

\_\_\_\_\_ Illness

\_\_\_\_\_ Emotions

\_\_\_\_\_ Medications

\_\_\_\_\_ Weather

\_\_\_\_\_ Exercise

\_\_\_\_\_ Smoke

\_\_\_\_\_ Foods

\_\_\_\_\_ Fatigue

\_\_\_\_\_ Chemical odors

\_\_\_\_\_ Allergies (Please list) \_\_\_\_\_

\_\_\_\_\_ Other (Please list) \_\_\_\_\_

4. What does your child do at home to relieve wheezing during an asthma attack? (Please check any that apply.)

\_\_\_\_\_ Rest/Relaxation

\_\_\_\_\_ Drinks liquids

\_\_\_\_\_ Breathing exercises (Please describe)

\_\_\_\_\_ Takes medication: \_\_\_\_\_ Inhaler \_\_\_\_\_  
(name medication) \_\_\_\_\_ Nebulizer \_\_\_\_\_

\_\_\_\_\_ Oral medication \_\_\_\_\_

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

5. In which sports can your child fully participate?

# ASTHMA HISTORY & TREATMENT FORM

SPIRIT in the PINES Camp

6. What medications does your child take and how often?

Every day \_\_\_\_\_

Just for wheezing/attacks \_\_\_\_\_

Before exercise \_\_\_\_\_

Certain times of the year or when ill \_\_\_\_\_

7. What, if any, side effects does your child have from his/her medication?

8. Does your child understand asthma and what he or she should do to manage it?

9. Approximately how often does the child have an acute episode?

10. How do you want SPIRIT in the PINES staff to treat an episode of asthma if it should occur?

11. If the child does not respond to medication what action does the parent/guardian advise the SPIRIT in the PINES staff to take?

COMMENTS:

Signature of Parent or Guardian \_\_\_\_\_

Use this form if you have a food allergy.

# Food Allergy Questionnaire

## SPIRIT in the PINES Camp

This questionnaire is designed to assist the camp staff in ensuring the safety of campers who have food allergies, as well as to assist in food/kitchen management. **Please provide an EPI-PEN for your child at camp, if needed.**

List food allergy and types of food(s) to avoid; provide additional ingredient list if needed:

What are preferred food substitutions, if any, as in the case of dairy/lactose allergy?

What, if any, modifications are necessary in the camp kitchen?

What is your child's reaction if ingested, please describe as fully as possible.

How should the staff treat an episode/reaction if it occurs?

Will other types of contact cause a reaction? If so, please describe fully.

Does your child understand the allergy and what he/she should do to manage it? Does your child need assistance with food choices in the dining hall and at canteen? What if anything, should the staff do to assist?

Please describe the last time a reaction occurred, providing detail on what caused it, the reaction, the treatment, and how long ago it occurred.

In the case of a peanut allergy, can your child eat foods such as M & M's which are processed in the same facility as peanuts? Please provide any additional detail which will be helpful.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Use this form if you will NOT be riding the bus TO/FROM camp

# CHANGE OF TRANSPORTATION

## DRIVING TO CAMP

CAMPER NAME \_\_\_\_\_ CAMP DATE \_\_\_\_\_

DATE AND TIME OF ARRIVAL AT CAMP \_\_\_\_\_

PERSON DROPPING OFF CAMPER \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

PHONE NUMBER REACHABLE ON DROP OFF DATE \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARENT PHONE REACHABLE ON DROP OFF DATE \_\_\_\_\_

(IF DIFFERENT FROM ABOVE)

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AT CAMP, DROP OFF SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

TIME \_\_\_\_\_

# CHANGE OF TRANSPORTATION

## PICK-UP FROM CAMP

CAMPER NAME \_\_\_\_\_ CAMP DATE \_\_\_\_\_

DATE AND TIME OF PICK-UP AT CAMP \_\_\_\_\_

PERSON PICKING UP CAMPER \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

PHONE NUMBER REACHABLE ON PICK-UP DATE \_\_\_\_\_

*SPIRIT IN THE PINES CAMP HAS PERMISSION TO RELEASE MY CHILD TO THE PERSON NAMED ABOVE.*

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARENT PHONE REACHABLE ON PICK-UP DATE \_\_\_\_\_

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AT CAMP, PICK-UP SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

TIME \_\_\_\_\_