Camp Okoboji Health Form

This form must be on file with Camp Okoboji prior to participation in any programming.

Participant Last Name ____________________________________ First Name ____ Date of Birth_____________________

Gender: M ( ) F ( ) Height _____feet ______inches Weight _________lbs Camp Program Attending _________________________ Attending Date___________________

E-Mail Address ______________________________________Address ____ City/State/Zip ___________________________

Mother's Full Name (if under 18)______________________ Day Phone ___________________ Night Phone _______________________ Lives with participant? **Yes No**

Father's Full Name (if under 18) ______________________ Day Phone ___________________ Night Phone _______________________ Lives with participant? **Yes No**

Emergency Contact Name ____ Relationship to Camper ____

Day Phone ____________________________ Night Phone ______________________________ In case of emergency, whom should we call first? __________________

Current Medications: Please note, all prescription medications MUST be prescribed to this individual, within expiration date, and in their original packaging.

Name of Medication	Reason for Taking	Dosage	Schedule

Health History

Condition	Circle One	If Yes:	Condition	Circle One	If Yes:	Condition	Circle One	If Yes:	Condition	Circle One	If Yes:	Condition	Circle One	If Yes:
Anxiety or Depression	No Yes	Current Past	**Recurrent Headaches**	No Yes	Current Past	**Heart Disease or Problems**	No Yes	Current Past	**Diabetes**	No Yes	Current Past	**ADD or ADHD**	No Yes	Current Past
Epilepsy or Convulsions	No Yes	Current Past	**Asthma**	No Yes	Current Past	**Frequent Colds**	No Yes	Current Past	**Frequent Ear Infections**	No Yes	Current Past	**Bed Wetting**	No Yes	Current Past
Ear, Nose, or Throat trouble	No Yes	Current Past	**Disease or injury to joints or back**	No Yes	Current Past	**Stomach or Intestine trouble**	No Yes	Current Past	**Dizzy Spells or Fainting**	No Yes	Current Past	**Home Sickness**	No Yes	Current Past
Eating Disorders	No Yes	Current Past	**Comments, other issues, physical limitations and/or list surgeries**											

Allergies/Dietary Needs

Type of Allergy	Circle One	Describe/Specify Allergen	Mild (Runny Nose, sneezing)	Moderate (Swelling or severe rash)	Severe (Systemic Response/Difficulty breathing)
Food	No Yes				
Medication	No Yes				
Environmental (animal, plant, insect, etc.)	No Yes				
Other	No Yes				
Vegetarian? No Yes Limitations:		Gluten Allergy? No Yes Limitations:		Lactose Intolerant? No Yes Limitations:	

Immunizations

Vaccination	Most Recent Date	Vaccination	Most Recent Date	Vaccination	Most Recent Date	Vaccination	Most Recent Date	Vaccination	Most Recent Date
Measles, Mumps, Rubella (MMR)		Hepatitis A		Hib		Chicken Pox (or had the disease)		Influenza	
Diphtheria/ Tetanus (DPT)		Hepatitis B		Polio		Other		Other	
Date of last Physical Exam : ___________________________		Physician Name:____				Physician Phone: (________)____________________			

Consent for Medication:

Do you authorize the Camp Okoboji staff to provide over-the-counter medication and topical creams according to package directions to this individual? **Yes No**

Is there any medication that you do not want our staff to provide?____

Medical Insurance:

Does this person you have medical insurance? **Yes No**

IF YES, please attach a copy of both the front and back of your health insurance card.

IF NO, please attach a signed letter stating that you agree to pay for any medical costs in the event of an emergency. These costs are not in any way covered by Camp Okoboji.

Authorization

I hereby give informed and expressed consent for this individual to take part in all camp activities under supervision, and agree that the camp or camp personnel will not be held responsible for accidents arising there from. I authorize the camp Health Care Provider and/or designated camp staff to provide appropriate treatment to this individual for injuries and/or illness. This includes, but is not limited to, following Camp Okoboji's medical procedures and protocols, following poison control recommendations, administering prescription medications as noted above, administering over the counter medications as approved above, transportation to clinic or hospital care, and following directions from the medical director. I understand that the information on this form may be released to the appropriate medical personnel in case of emergency. I agree to pay any cost for medical care in the event of an emergency, even if I do not have health insurance coverage or not all costs are covered by insurance. I also understand that failure to disclose medical or emotional problems in advance may lead to serious consequences while at camp. Lastly, I verify that everything contained on this form is complete and accurate, to the best of my knowledge.

Parent/Guardian Signature
OR Participant Signature if over 18____ **Date**____