

Saguaro Camp Cedarbrook Camper Health Form

(Page 1 of 2)

Camp Use Only

Please complete in full and return at least **one week prior** to camp to:

Saguaro Camp Cedarbrook Girl's Registrar at 6325 W. Cortez St., Glendale, AZ 85304. Or boy's Registrar at 3829 W. Cheryl Dr., Phoenix, AZ 85051

1. Participant's Legal Name _____ Male Female
(Last, First)

Age _____ Birthdate ____/____/____ Camp Dates: _____

2. Parent/Guardian phone _____ (H) _____ (W) _____ (C) _____

Home Address _____ City _____ State _____ Zip _____

E-mail _____

Parent/Guardian _____ (H) _____ (W) _____ (C) _____

Home Address _____ City _____ State _____ Zip _____

Email _____

Person **other than** Parent/Guardians to contact in case of an emergency _____

Relationship _____ (H) _____ (W) _____ (C) _____

May the camp release the camper to the person named above for pick-up? Yes No

3. Does the participant have any form of **health insurance**?

No – *The participant or his/her parent/guardian will be financially responsible for the full amount of any medical bills.*

Yes – Policy holder's date of birth: (mm/dd/yyyy) ____ / ____ / ____ Expiration date _____

Photocopy both sides of your Health Insurance/ Medicaid Card. If photocopy will fit, cut to size and attach it here.

Health Insurance Card

FRONT

**Insurance Company Phone Number
Must Be Legible**

*Cut photocopy to size and attach here.
If card is too large, attach/staple full sheet.*

Health Insurance Card

BACK

**Insurance Company Phone Number
Must Be Legible**

*Cut photocopy to size and attach here.
If card is too large, attach/staple full sheet.*

4. Primary Doctor _____ Phone _____

Dentist Name _____ Phone _____

Other Specialist _____ Type _____ Phone _____

REQUIRED AUTHORIZATIONS: Signed by Parent/Guardian (Please make a copy of this form for your records.)

5. The information on this form is correct so far as I know, and the participant has my permission to engage in all camp activities that are part of the program they are enrolled in, as described in the brochure and parent packet, on or off camp property, **except as noted on the back of this form.** It is very important to complete all portions of this form.

• **SIGN BELOW FOR GENERAL PERMISSION TO PARTICIPATE IN Saguaro Camp Cedarbrook ACTIVITIES:**

(Print Name) _____ (Signature) _____ (Date) _____

6. I hereby give permission to the Saguaro Camp Cedarbrook nurses to provide routine non-surgical health care; to administer prescription medications I've supplied, as well as over-the-counter medications appropriate for the situation; and to transport the participant to the next level of medical care if required. I understand that all medicines I've supplied must be in original containers with participant's name on them. I hereby consent to the release of personal medical information to any licensed health care provider or camp staff as needed to provide care to the participant. In the event I cannot be reached in an emergency, I hereby give permission to the licensed health care provider selected by the camp to secure and administer treatment, order x-rays, order routine tests, hospitalize, and order injection, anesthesia or surgery for the participant. This completed form may be photocopied for trips out of camp. I understand that I am financially responsible for medical bills due to office/ER visits and/or pharmacy charges. • **SIGN BELOW FOR PERMISSION TO TREAT AND TO ACCEPT FINANCIAL RESPONSIBILITY:**

(Print Name) _____ (Signature) _____ (Date) _____

TWO-SIDED FORM – SEE BACK

Cabin: _____ Camper Name: _____ Counselor: _____ Division: _____

Participant's Legal Name (Last, First) _____

HEALTH HISTORY: **Completed by Parent/Guardian** (Please make a copy of this form for your records.)

7. Has the participant had any of the following (childhood) **diseases** or illnesses? Circle answer and give approximate year:

Chicken Pox **no** **yes**:_____ Measles **no** **yes**:_____ German Measles **no** **yes**:_____ Mumps **no** **yes**:_____

8. Has the participant had a **tetanus shot within ten years**? If yes, date: ___/___/_____ and circle answer → **no** **yes**

If available, please attach a copy of immunization history

9. Are the participant's **immunizations up to date**? If no, explain: _____, and circle answer → **no** **yes**

If the participant has not been fully immunized, please sign the following statement:

I understand and accept the risks to the participant from not being fully immunized.

Signature _____ Date _____

10. Has the participant **traveled internationally** within the past 9 months? Circle answer (if yes, explain below) → **yes** **no**

11. Any **serious illnesses or major operations / medical treatments**? Circle answer (and if yes explain below) → **yes** **no**

12. Any **current infectious diseases**? If yes explain: _____ and circle answer → **yes** **no**

(Please let us know if the participant is exposed to any infectious diseases after submitting this form and before camp starts.)

13. (**Females**) Has she menstruated? Circle answer → **no** **yes** If no, does she understand the process? Circle answer → **no** **yes**

HEALTH STATUS: **Completed by Parent/Guardian** (Please make a copy of this form for your records.)

14. Any **allergies or dietary restrictions** that we should know about? Circle answer (and if yes, circle/list below) → **yes** **no**
penicillin peanuts wheat/gluten bee stings hay latex vegetarian Other: _____

15. Any **physical conditions** that may affect participation at camp? Circle answer (and if yes, circle/list below) → **yes** **no**
asthma bed wetting hemophilia cancer lung disease Crohns/IBS orthopedic problem PMDD
epilepsy motion sickness fainting diabetes heart disease back/neck injury eczema vision impairment
hearing loss high/low BP kidney disease RA Other: _____

16. Any **recent broken bones / major injuries**? If yes, list: _____, and circle answer → **yes** **no**

→ **If you answered "yes" to questions 14, 15, or 16, please list here any camp-related ACTIVITY RESTRICTIONS:**

Attach a **separate sheet** that describes the **condition**, the **MANAGEMENT PLAN**, and **anything camp needs to do to help**.

17. Any **mental/psychological needs** that will have an impact on camp interaction/participation? Circle answer → **yes** **no**
If **yes**, circle and/or list: anxiety disorder ADHD depression dyslexia autism oppositional defiant disorder
eating disorder OCD bipolar disorder PTSD Down syndrome Other: _____

→ **If you answered "yes" to question 17, attach a separate sheet that describes the concern, the MANAGEMENT PLAN (including meds), and the behaviors that will indicate to our staff that the participant's parent/guardian needs to be notified, or in case of emergency, the participant's doctor.**

18. Please list any medication your child takes on a regular basis: _____

19. Anything else you want us to know related to the participant's health that we did not ask?

(For camp use.) Camper Name: _____
Cabin: _____
Counselor: _____
Division: _____