

For Youth Camper- Camp Finland Statement of Health Record -

Participant Name: _____ D.O.B.: _____

Legal Parent Guardian Contact: _____ Phone(s) _____

Other Contact in case of emergency: _____ Phone(s) _____

Doctor's Name (If applicable): _____ Date of last medical check-up: _____

Doctor office location: _____ Phone: _____

Medical History

Certain camp activities may expose youth to more strenuous movement (e.g. hiking) or allergens (e.g. craft supplies, food, outdoor activities) than they are used to. We do not want campers to engage in activities that would be detrimental to their health. We ask for the following information so we can be aware of potential problems and risks and so we will be better able to provide safe, enjoyable activities. This document will also be copied and carried with staff during off-site activities. If a potential emergency arises and medical professionals need to be called, a copy of this document will be handed to the medical professionals.

Does your child have:

Any condition requiring regular medications? If so, name the medications, the amount, and the frequency taken:

Any injuries within the last three years such as, concussions, dislocations, sprains, fractures, hernias, torn ligaments, separations? If so, identify the type of injury, when it occurred, the extent and severity, the treatment, and state whether or not the participant fully recovered: _____

Other physical disabilities or impairments of sight, hearing or speech? _____

Emotional or behavioral challenges (i.e., phobias): _____

Any physical conditions that might prevent you from fully engaging in any activity? _____

Has your child been treated by a medical or mental health practitioner within the last year? If so, please explain. _____

Do you wear contact lenses? _____ **Hearing Aid?** _____

Allergic to any medications? _____ **What type?** _____

Allergic to insect bites or stings? _____ **What happens?** _____

Have you ever been stung by a bee, wasp or hornet? _____ **When?** _____

Allergic to certain types of clothing materials? _____ **Soaps?** _____

Allergic to any foods? _____

Allergic to anything in the environment? _____

Describe any special dietary requirements. _____

Any hospitalizations? Please explain. _____

Date of last tetanus shot? _____

Has your child ever had any of the following conditions?

YES	NO		YES	NO	
___	___	Allergies	___	___	Convulsions
___	___	Diabetes	___	___	Mononucleosis
___	___	Meningitis	___	___	Severe Headaches
___	___	Epilepsy	___	___	Mumps
___	___	Asthma	___	___	Pleurisy
___	___	High Blood Pressure	___	___	Rheumatic Fever
___	___	Back Problems	___	___	Tuberculosis
___	___	Hypersensitive to cold	___	___	Ulcer
___	___	Hypersensitive to heat	___	___	Gastrointestinal problems (i.e., diarrhea, constipation)
___	___	Insomnia	___	___	Eye, ear, nose, throat, sinus symptoms
___	___	Chronic cough/coughing blood	___	___	Muscle Cramps
___	___	Chicken Pox	___	___	Problems related to menstruation
___	___	Colitis	___	___	Skin Condition
___	___	Heart Murmur/Palpitation	___	___	Joint pain, sciatica, bursitis
___	___	Loss of appetite	___	___	Dizziness

If you answered yes to any of the conditions listed, please explain when, for how long, treatment, lingering effects, etc. Use an additional sheet of paper if more room is needed. _____

Any other information concerning your youth's medical history or condition? _____

Name of Insurance Company _____

Address _____

Policy Number _____ **In whose name** _____

Medical Emergency Release Statement:
(Please be assured that every effort will be made to contact you in the event of an emergency.)

I, _____ (Participant) assume full responsibility for my health being such that the activities will in no way aggravate any condition. If I have any doubt about my physical conditions or capabilities, I will discuss them with the Camp Finland Staff. Should it be necessary to incur additional expenses and/or medical or emergency treatment during the camp week, we give the Camp Finland Staff permission to use their judgment in such matters. I declare the statements on this form to be true. In case a medical, surgical, or mental health emergency occurs, and the "Contact Person in Emergency" cannot be reached promptly, I hereby give permission for medical or mental health intervention, and/or anesthesia and surgery, to be administered to me by appropriate medical personnel as designated by Camp Finland staff.

Parent/Legal Guardian Signature _____ **Date** _____

If there is any additional information about your camper you'd like staff to know please write it on another piece of paper and send it along with this medical form and registration/behavior agreement.