# Health Form (Camp Wing Nurse)

*Can be used by campers and staff for all Crossroads Connects programs*

Name_____ Social Security Number_____ D.O.B. __/__/____ Age____ M or F

Parent/Guardian Name _____ Home Phone _____Work _____Cell_____

Home Address _____

**INSURANCE Name & Address:** _____

Subscriber: _____ Policy #: _____ Group #:_____ Phone #:_____

**EMERGENCY CONTACT:** *Every effort will be made to contact the parent/guardian in the event of an illness or other problem. Please indicate **2 other persons** who know your child, who have **authorization for transportation,** and who may be contacted if necessary.*

Name_____Relation_____ Telephone _____Cell/Pager _____

Name_____Relation_____ Telephone _____Cell/Pager _____

**ALLERGIES** *List all known. Describe reaction and management of the reaction*.

**Medication Allergies** (list)

_____ _____

_____ _____

**Food allergies** (list)

_____ _____

_____ _____

**Other allergies** (list) – include insect stings, hay fever, asthma, animal dander, etc.

_____ _____

_____ _____

**MEDICATIONS BEING TAKEN:** *Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. **Bring enough medication to last the entire time at camp.** Keep it in the original package/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.*

❑ This person takes NO medications on a routine basis.

❑ This person takes medications as follows: *(Attach additional pages if needed for more medications)*

**Med # 1** _____ Dosage _____ Specific times taken each day_____
Reason for taking _____

**Med # 2** _____ Dosage _____ Specific times taken each day_____
Reason for taking _____

*Identify medications taken during the school year the participant does not/may not take during the summer:*

**GENERAL QUESTIONS (explain yes answers below):**

| Has/does the participant: | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| 1. Had any recent injury, illness or infectious disease? | ❑ | ❑ | 8. Ever been hospitalized? | ❑ | ❑ |
| 2. Have a chronic or recurring illness/condition? | ❑ | ❑ | 9. Ever had seizures? | ❑ | ❑ |
| 3. Wear glasses, contacts or protective eye wear? | ❑ | ❑ | 10. Have diabetes? | ❑ | ❑ |
| 4. Have any skin problems (e.g., itching, rash, acne)? | ❑ | ❑ | 11. Have asthma? | ❑ | ❑ |
| 5. Had any problems with diarrhea/constipation? | ❑ | ❑ | 12. Have a history of bed-wetting? | ❑ | ❑ |
| 6. If female, have an abnormal menstrual history? | ❑ | ❑ | 13. Ever had emotional difficulties for which professional help was sought? | ❑ | ❑ |
| 7. Ever had an eating disorder? | ❑ | ❑ | | | |

**Please explain any "yes" answers, noting the number of the questions:**

AGE

DATE OF BIRTH (m/d/y)

GENDER

FIRST NAME

LAST NAME

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.

Name of family physician _____Office Phone:_____ Location _____

Name of family dentist/orthodontist_____Office Phone:_____ Location _____

## SIGNATURE OF PARENT/GUARDIAN REQUIRED HERE: PLEASE READ CAREFULLY.

This health history is correct as far as I know and the person herein described has permission to engage in all camp activities except as noted. **Authorization for release of information.** I hereby authorize Crossroads for Kids to obtain and/or release whatever educational, psychological, or medical information and records as deemed necessary. **Authorization for Distribution of Prescriptions:** I hereby authorize Crossroads for Kids to administer, to the person herein described, the medications (listed above or prescribed while at camp by a physician), in accordance to the regulations listed in CMR101. **Authorization for Routine Medical Treatment:** I hereby authorize the Camp to give routine medical care as outlined in the standing orders for the camp. **Emergency Authorization:** I hereby give permission to the medical personnel selected by the Camp Director to order x-rays, routine tests, and treatment for me/or my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me/or my child as named above. This form may be photocopied for use out of camp. I will assume all financial responsibilities for emergency treatment for me/or my child not covered by the camper medical insurance.

►**Signature of Parent/Guardian** (if participant is under 18) _____ Date _____

***Participants 18 or older may sign this form on their own behalf.***

# Waiver/Release of Liability

*To be filled out on behalf of all participants of Crossroads Connects programs*

**Promotional Materials:** Unless I cross out this section regarding promotional materials, I agree that photos/videos/other media may be taken of my child & may be used for future promotional materials, including the Crossroads for Kids, Inc. website.

**Release:** I give permission for my child to attend camp and participate in all programs, which may include activities off of the camp premises. I agree that Crossroads for Kids, Inc. will observe all reasonable precautions for the care and protection of my child. I understand that staff selection policies and procedures including confirmation of background checks, and healthcare and discipline policies, are available to parents or guardians at their request. I understand that I may contact the office during business hours to file any grievances. By signing this form, I hereby release and hold harmless the camp, and its directors, officers, employees, agents, and representatives, from any and all damages, claims, injuries and liabilities, which may arise out of my child's attendance at camp and out of his/her participation in any activities while in attendance.

Is there anything else we need to know so we can help your child have a fun, well adjusted experience?

_____

_____

_____

_____

Signature: _____

Date: _____