

Primitive Camping Health & Release Form

THIS SECTION TO BE FILLED OUT BY PARENT(S)

Camper _____
Age _____ **Sex** _____ **Birthdate** _____
Birthplace _____ **Religion** _____
Parent/Guardian _____
Address _____
City/State/Zip _____
Home Phone _____
Work Phone(s) _____
Cell Phone(s) _____

Attach a copy of the front of your insurance card here.

If you do not have insurance, note the following and sign:

Credit Card type Visa MasterCard _____

Credit Card Number: _____

Expiration: _____

Signature: _____

Attach a copy of the back of your insurance card here.

Emergency Contact

Name _____
Relationship _____
Address _____
City/State/Zip _____
Home Phone _____
Work Phone(s) _____

This health history below is correct to the best of my knowledge, and the camper herein described has permission to engage in all prescribed camp activities, except as restricted by my or the examining physician's notation on this form, with the understanding that the camper is engaged in primitive camping. Understanding that every reasonable effort will be made to reach me, I hereby give permission to the camp administrator or his/her designee to secure treatment for the camper that is deemed needed or appropriate, at a medical facility of his/her choosing, and the physician so chosen to provide such care, to include, if deemed necessary, hospitalization, injection(s), administration of anesthesia, or surgery. Responsibility for payment of any such services remains my own, regardless of insurance status. I agree to notify camp authorities if the camper is exposed to communicable diseases in the 3 weeks prior to the beginning of camp and to any significant changes in health status prior to camp onset.

Date _____ **Signature of Parent/Guardian** _____

THIS SECTION TO BE FILLED OUT BY EXAMINING PHYSICIAN

Medication and Environmental Allergies and Intolerances

bee sting
 poison ivy/oak/sumac
 hay fever
 penicillin
 erythromycin
 sulfa

Restrictions and Limitations

Describe any and all other potential restrictions on activities, keeping in mind that 11-18 year olds especially will be in primitive facilities ¼ mi. from main buildings and have a planned 3-day hike away from ready medical access. Comment on the child's independence and ability in: 1) abiding by dietary restrictions; performing ADLs independently including hygiene; calorie counting, monitoring serum glucose, calculating and administering own insulin injection; developmental/behavioral/psychiatric issues; enuresis; ability to participate in sports, swimming, backpacking at age-appropriate level.

Prescription and Over-the-Counter Medications

List all medications routinely taken, including emergency medications (e.g. Epi-pen). Specify medication name, dose, and frequency. Print clearly!

Immunizations

Give the latest date for the following immunizations; dates of completion of series. If not received, not completed, or unknown, so note.

DPT series: _____ **MMR:** _____ **HIB:** _____ **Blood type:** _____
Last Tetanus: _____ **OPV:** _____ **Hep.B:** _____
Type: _____ **PPD:** _____ **VZV:** _____

Past Medical History

List ongoing or recurrent medical conditions for which the camper is receiving medical care, prior surgeries, major infectious diseases, etc..

- tuberculosis rheumatic fever chicken pox measles German measles mumps
 kidney disease heart disease hypertension diabetes freq. otitis media asthma
 fainting spells seizures bleeding/clotting disorder mononucleosis abnl. menses
 noct. enuresis somnambulism behavioral issues (explain below)

Physical Examination

Height _____ Weight _____ kg. lb. B.P. _____ Pulse _____ Acuity _____ O.D. _____ O.S. _____

	NL	Abnl. / Comments
Skin	<input type="checkbox"/>	_____
Head	<input type="checkbox"/>	_____
Eyes	<input type="checkbox"/>	_____
Ears	<input type="checkbox"/>	_____
Nose	<input type="checkbox"/>	_____
Throat	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	_____
Abdomen/GI	<input type="checkbox"/>	_____
Extremities	<input type="checkbox"/>	_____
Genitourinary	<input type="checkbox"/>	_____
Musculoskeletal	<input type="checkbox"/>	_____
Neurologic	<input type="checkbox"/>	_____

Comments, Other Positives, or Significant Negatives**Family Physician**

Name, Degree _____

Address _____

City/State/Zip _____

Phone _____

Examining Physician

Name, Degree _____

Address _____

City/State/Zip _____

Phone _____

Physician Signature

License# _____

State _____

Date Examined _____

Signature _____