Camp High Hopes - 2010

Camper Health Form - to be Completed by Parents.

Must Be Returned by July 4, 2010

Name: ____ Age: ______ DOB:________________

Parent or Guardian____ Date: __________________________

Address: ____ Zip Code: _____________________

Home Phone: (_____) _______________________ Work Phone: (_____) __________________________

▪ **Emergency Contact:** can we give this person medical information about this child? Yes ___ No ___

Name: _____________________________________ Relationship: _______________________________

Phone: _________________________ Address: ____

▪ Physician's Name: ____

Phone: _______________________________ Contact Person: _________________________________

▪ Treatment Center: ____

Phone: _______________________________ Contact Person: _________________________________

▪ Clotting Disorder & Factor Level: Factor 8 ______% Factor 9 _____% Other Factor ______ %

Type of Von Willebrand's _________________ Does child have an inhibitor? YES ___ NO ___

▪ Mark "Yes" or "No" to each one:

Frequent sore throat	________	Habits/Rituals	________
Frequents cold	________	Rashes	________
Sinus infections	________	Sleepwalking	________
Stomach problems	________	Fainting	________
Kidney disease	________	Appetite loss	________
Heart disease	________	Fevers	________
Hay fever	________	Sun sensitivity	________
Asthma	________	Bedwetting	________
Seizures	________	Unique behaviors	________
Diabetes	________	Homesickness	________
Constipation	________	Fears/phobias	________
Diarrhea	________	Loose teeth	________
Tubes in ears	________	Glasses/contacts	________
Swimmer's ear	________	Nose bleeds	________
Catheter	________	Infusaport/Medport	________
Bad dreams	________	Other	________

If yes to any of the above, please explain:____

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▪ Allergies to medicine, insects or foods? Yes: ____ No: ____ Explain: ______________________

____

____

Does your child receive allergy shots? Yes ____ No ____

▪ If the child is on a special diet please describe: ____

____

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▪ Is your child on any medications at this time? Please list medicine, dosage and reason below.

Scheduled Medication:	Dose	Tines to be given:	Reason to give this medicine:

"As Needed" Medication:	Dose	Times to be given	Reason to give this medicine:

1) You must bring all above medicines to camp. 2) All medicine must come with written instructions from doctor. 3) All medicine given under the direction of the Camp Nurse.

▪ IMMUNIZATIONS: MUST BE COMPLETED OR YOUR CHILD CAN NOT ATTEND CAMP!

	Original dates	Date of booster
Polio		
DPT		
Measles, Mumps, Rubella (MMR)		
Hepatitis B vaccine		
Hepatitis A vaccine		
Tetanus		
Chicken Pox vaccine		
Haemphilus Influenza (h. flue)		

Has child had: Chicken pox? Yes___ No ___ Hepatitis? Yes___ No ___ What type?______

► PARENTS MUST CALL THE CAMP HEALTH DIRECTOR AT 607-729-7969 ◄

IF THIS CHILD IS EXPOSED TO COMMUNICABLE DISEASES (such as Measles, Mumps, German Measles, Chicken Pox, etc.) WIITHIN 3 WEEKS OF THE START OF CAMP!

▪ Do they have physical limitations or restrictions from any activities? ____________________________

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▪ Does your child wear any splints or braces? ______________________________

How/when are these worn? ______________________________

____

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____

▪ Name of FACTOR CONCENTRATE used ______________________________

▪ Is your child on prophylaxis? Yes _____ No _____

List the Dose and which Days given: Sunday _______________ Monday _______________

Tuesday _______________ Wednesday _______________ Thursday ______________

Friday _______________ Saturday _______________

Is your child on home care? Yes ____ No ____

Does your child self infuse? Yes ____ No ____

▪ How many times does your child bleed? Weekly: ______ Monthly:______ Yearly: ______

Does your child have any reactions to factor infusions? ______________________________

____

Does your child receive any medication before his treatments? ______________________________

____

▪ If your child has Willebrand's is Stimate used? (BRING the treatment sheet with you).

Type of bleed:	Dose & Frequency	Does your child also use Amicar for this?
________________	________________	________________
________________	________________	________________

1) You must bring a supply of the child's factor, infusion supplies, and other clotting medicine to camp. 2) YOU WILL RECIEVE A LETTER before camp from the Health Director reminding you what medicines, factor, and other supplies to bring to camp.

► Is there any thing else we should know about this child in order to take good care of them at camp?

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HEALTH INSURURANCE INFORMATION

Name of Policy Holder:____

Name of Insurance: ____

Subscriber Number: ____

Policy / Group Number: ____

* STATE AID____

* MEDICAID____

* OTHER____

I attest that this insurance information is correct, and that the insurance listed above is valid and covers the camper listed on this medical form. Furthermore, I agree to pay any costs not covered by this insurance which may be incurred as part of any medical treatment for this camper.

Signature of Parent/Guardian____

AUTHORIZATION & CONSENT
FOR MEDICAL TREATMENT OF A MINOR CHILD:

I, being the parent or guardian of this child, do hereby give permission to the Camp High Hopes Health Director and Medical Staff to treat this child for their bleeding disorder AND any other urgent/emergency medical need they may have during camp. This may include taking the child to an off camp medical facility at the discretion of the Camp High Hopes Health Director and without giving prior notification to the parents/guardians. Furthermore I give permission for the Camp High Hopes Medical Staff to give medical information about this child to other medical care givers as is needed for such treatment. I accept full responsibility for all costs incurred as a result of emergency care and/or inpatient treatment.

Name(s): ____

Parents _____ Guardians _____ Date ____________________

Signature(s): ____

Signature(s): ____

Witness: ____________________________________ Date:______________________

Address of Witness: ____

Signature of Witness: ____

Return this form by July 4 to: Camp High Hopes
c/o Hope Woodcock R.N. – Health Director
Box 11038
Syracuse, NY 13208