

# Camp Sunrise

## 2010 Camper Medical Form

**Note: If your child has medical, behavioral or dietary considerations, it is important that you let Camp Sunrise know so that we can ensure he/she has the safest and most successful camping experience possible.**

### GENERAL INFORMATION:

Surname: \_\_\_\_\_ First Name: \_\_\_\_\_ Gender: \_\_\_\_\_

Date of Birth: (d/m/y) \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Care Card Number: \_\_\_\_\_

Parent's/Guardian's Name: \_\_\_\_\_

Parent's/Guardian's Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name of Camper's Physician: \_\_\_\_\_ Physician's Phone # \_\_\_\_\_

Medical History: Please check if the camper has experienced any of the following:

- |  |   |  |                                      |
|--|---|--|--------------------------------------|
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Convulsions      | <input type="checkbox"/> Bedwetting              | <input type="checkbox"/> Toothaches  |
| <input type="checkbox"/> Chicken Pox       | <input type="checkbox"/> Fainting         | <input type="checkbox"/> Appendicitis            | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Severe Nosebleeds | <input type="checkbox"/> Ear Infections   | <input type="checkbox"/> Urinary Tract Infection | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Severe Headaches | <input type="checkbox"/> Severe Stomach Aches    | <input type="checkbox"/> Other _____ |

Does the camper have any other medical, emotional or behavioral conditions of which we should be aware?

(Please attach additional pages if necessary)

---

---

---

---

---

---

Are the camper's vaccinations up to date?  Yes  No

What was the date of the camper's last tetanus shot? \_\_\_\_\_

**ALLERGIES:** Please list all allergies of your child (food, medication, environmental, etc.)

- 1.** Allergy: \_\_\_\_\_  
Reaction: \_\_\_\_\_  
Severity: \_\_\_\_\_  
Treatment Required: \_\_\_\_\_
- 2.** Allergy: \_\_\_\_\_  
Reaction: \_\_\_\_\_  
Severity: \_\_\_\_\_  
Treatment Required: \_\_\_\_\_
- 3.** Allergy: \_\_\_\_\_  
Reaction: \_\_\_\_\_  
Severity: \_\_\_\_\_  
Treatment Required: \_\_\_\_\_

Does your child carry an Epi-pen?  Yes  No

If yes, does your child know how to use his/her Epi-pen?  Yes  No

**DIETARY RESTRICTIONS:** Please indicate whether your child has any dietary restrictions, other than food allergies noted above.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS (Over-The-Counter):** Camp Sunrise maintains a small supply of over-the-counter medications including Tylenol, Ibuprofen, Cough Lozenges/Syrups, Gravol, and Benadryl. Do you give Camp Sunrise permission to dispense such medications to your child if deemed appropriate?  Yes  No

Signature of Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICATIONS:** Please list all medications the camper is presently taking (attach additional pages if necessary). With the exception of Epi-Pens and Asthma Puffers, all medications will be stored and dispensed by the Camp Health care Provider. It is recommended that the camper's physician prepare a letter describing, in detail, the camper's condition, treatment and any unexpected problems that may arise from that condition.

**1.** Name of Medication: \_\_\_\_\_

Reason for Treatment: \_\_\_\_\_

Dosage: \_\_\_\_\_

When Taken: \_\_\_\_\_

**2.** Name of Medication: \_\_\_\_\_

Reason for Treatment: \_\_\_\_\_

Dosage: \_\_\_\_\_

When Taken: \_\_\_\_\_

**3.** Name of Medication: \_\_\_\_\_

Reason for Treatment: \_\_\_\_\_

Dosage: \_\_\_\_\_

When Taken: \_\_\_\_\_

**HEAD LICE:** In our efforts to provide the best possible experience for all campers, it is imperative that parents(s)/guardians(s) check their child for evidence of lice prior to coming to camp. Upon arrival to Camp Sunrise, as part of the registration process, each camper will be checked for lice and provided treatment if necessary.