

CASCADE SUMMER CAMPS

Questions: Rachel Osias, Camp Admin, (206)939-4339, rachelo@cascade.org

CAMPER MEDICAL FORM



(Please complete, print, and bring on the first day of camp. Page #3 onward must be completed one per camper.)

Form must be COMPLETED for camper's participation in summer programming.

CAMPER/S NAME/S:				
PARENT/GUARDIAN				
LAST		FIRST		RELATION TO CAMPER:
PRIMARY EMAIL				
ADDRESS		CITY	STATE	ZIP
PRIMARY PHONE ()			SECONDARY PHONE ()	
PARENT/GUARDIAN #2 (Optional) Please enter someone besides yourself.				
LAST		FIRST		RELATION TO CAMPER
EMAIL				
ADDRESS		CITY	STATE	ZIP
PRIMARY PHONE ()			SECONDARY PHONE ()	
ADULTS AUTHORIZED TO PICKUP CHILD (Please list the first and last name of the adults authorized to pickup your child)				
LAST		FIRST		RELATION
LAST		FIRST		RELATION
LAST		FIRST		RELATION

EMERGENCY CONTACT (Please add a contact other than yourself or Parent/Guardian #2)		
LAST	FIRST	RELATION TO CAMPER
AUTHORIZED TO PICKUP CAMPER? (If yes, this Emergency Contact is authorized to act on behalf of a Parent/Guardian if they are not able to be reached.) <input type="checkbox"/> YES <input type="checkbox"/> NO		PHONE: () SECONDARY PHONE: ()
EMERGENCY CONTACT #2 (Please add a contact other than yourself or Parent/Guardian #2)		
LAST	FIRST	RELATION TO CAMPER
AUTHORIZED TO PICKUP CAMPER? (If yes, this Emergency Contact is authorized to act on behalf of a Parent/Guardian if they are not able to be reached.) <input type="checkbox"/> YES <input type="checkbox"/> NO		PHONE: () SECONDARY PHONE: ()
INSURANCE & PHYSICIAN INFORMATION -- Is the camper covered by medical insurance? (circle one) YES / NO		
FAMILY PHYSICIAN NAME:		PHONE:
DENTIST/ORTHODONTIST NAME:		PHONE:
HEALTH INSURANCE PROVIDER:	HEALTH INSURANCE GROUP #:	HEALTH INSURANCE POLICY #:
NAME OF HEALTH INSURANCE POLICY HOLDER:		RELATIONSHIP TO CAMPER/S:

REMINDERS:

Do you have multiple children attending camp?

- Pages 1 & 2: only ONE COPY needed for all of your attendees.
- Page 3 & 4: ONE PER CHILD please.

HEALTH HISTORY -- Does this camper currently have, or have they ever been treated for the following?

Yes	No	CONDITION	
		Asthma	Last attack date: _____ (Inhaler must be present EVERYday of camp.)
		Been hospitalized	If yes to any, please explain:
		Recent injury, illness or infectious disease	
		Chronic or recurring illness	
		Homesickness	
		Seizure disorder or convulsions	
		Dizziness during or after exercise	
		Heart defect/disease or chest pain during/after exercise	
		Bleeding/clotting disorders	
		Diabetes	
		Joint problems (knees, ankles, etc)	
		Fractures/breaks	
		Frequent headaches	
		Head injury	
		Eating disorder	
		Frequent stomach aches, and/or diarrhea or constipation	
		Wears glasses or contact lenses	
		Deaf or hearing loss	
		Wears a Medic Alert ID	

WHAT HAVE WE FORGOTTEN TO ASK? -- In the space below, please provide any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. Attach additional information as needed.

HEALTH & MEDICAL AUTHORIZATION

My camper/child has permission to engage in all prescribed camp activities except as noted. The information provided on this form is accurate to the best of my knowledge. I have indicated any special health conditions, including required medication and activity limitations which should be known to the camp staff and medical personnel. All information will be kept confidential amongst Cascade Summer Camp Staff and medical personnel. I am aware of and accept the risk inherent in the program/s activities. I give consent in advance for medical treatment in the case of illness or injury.

Signature of Parent or Guardian: _____

Date: _____

YOUTH/CAMPER

LAST	FIRST	MI	DOB (mm/dd/yyyy)	GENDER <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/> Prefer not to say
Height:	Weight:	T-SHIRT SIZE: <input type="checkbox"/> Youth Small <input type="checkbox"/> Youth Medium <input type="checkbox"/> Youth Large <input type="checkbox"/> Youth XLarge <input type="checkbox"/> Adult Small <input type="checkbox"/> Adult Medium <input type="checkbox"/> Adult Large <input type="checkbox"/> Adult XLarge <input type="checkbox"/> 2XL		

MENTAL, EMOTIONAL, AND SOCIAL HEALTH -- Check "Yes" or "No" for each statement.

Yes	No	Has the camper:
		1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?
		2. Even been treated for emotional or behavioral difficulties or an eating disorder?
		3. During the past 12 months, seen a professional to address mental/emotional health concerns?
		4. Had a significant life event that continues to affect the camper's life? (History of abuse, death of a loved one, family change, foster care, etc.)
<p>Please explain "Yes" answers in the space below, noting the number of the question/s. Camp administrators may contact you for additional information.</p> <p>Is there anything else you would like us to know about your child that would help us give your camper the best experience at camp?</p>		

ALLERGIES -- Is the camper allergic to or do they have any adverse reactions to any of the following?

Yes	No	Allergies or Reactions	Explain
		Medication	
		Food	
		Plants or animals	
		Insect bites/stings	

Does your camper require an EpiPen for any of the above stated allergies? (circle one) YES / NO

If yes: The camper MUST have their EpiPen with them at camp EVERYday. Parent/Guardians will be asked to return home with their camper for the EpiPen if they do not have it upon arrival.

MEDICATIONS -- List all medications currently used, including any over-the-counter medications.

CHECK HERE IF NO MEDICATIONS ARE ROUTINELY TAKEN IF ADDITIONAL SPACE IS NEEDED PLEASE INDICATE ON SEPARATE SHEET AND ATTACH

Medication	Dose	Frequency	Reason	Taking at camp? y / n

Please note that Cascade Camp Staff are not able to administer medications, other than EpiPen/s in the case of an emergency.