2008 Adventure Week Health Form
for Sponsoring Organization Chaperone

August 10 – 15, 2008

Chaperone Information

Name: ______________________________
Last First Middle

Social Security # __ __ __-__ __-__ __ __ __ Date of Birth ____/____/____ Age ____________________

Parent/Guardian Name: ____

Address ____

City, State, Zip ____

Home Phone (______)________________________ Work/Cell Phone (______)________________________

Emergency Contact Name ______________________________ Phone (______)________________________

Sponsoring Organization ____

Contact Name ____ Phone (______)________________________

Medical Information

Does the camper take any medications? Yes ____ (describe below) No _____

Please list any medications (including over the counter or non-prescription drugs) taken regularly. Bring enough medications to last the entire time at camp. Keep medications in their original bottle/package that identifies the prescribing physician (if prescription), the name of the medication, the dosage, and frequency of administration.

Med #1____________________________Dosage_____Specific times taken each day ____________________________

Reason for taking____

Med #2____________________________Dosage_____Specific times taken each day ____________________________

Reason for taking____

Med #3____________________________Dosage_____Specific times taken each day ____________________________

Reason for taking____

Does the camper have any allergies? Yes____(describe below) No_____

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Does the camper know how to swim? Yes____(describe ability below) No_____

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Parent/Guardian Authorization & Acknowledgement of Risk

I give permission to the medical personnel selected by the Director of Camp Rockmont or his designee to provide routine health care; to administer medications; order x-rays, routine tests & treatment; to release any records necessary for insurance purposes; or to provide or to arrange necessary related transportation for myself. In an emergency, I give permission to the medical personnel so selected to secure and administer treatment including hospitalization for myself. I give permission for photographs and/or audio/video recording of myself to be used by the camp for its promotion, website and/or news media coverage. I acknowledge that there are inherent risks to participation in recreational and adventure activities and programs offered by Camp Fun including but not limited to swimming, canoeing, climbing, target sports, and adventure elements, which could result in accidental injury, possibly serious. Parents will be notified immediately if a serious incident occurs. Furthermore, participation in these activities good physical condition by the participant. Being aware of the inherent risks and potential injury to myself, I hereby consent to my attendance and participation in the activities offered by Camp Fun.

Signature of Parent/Guardian______________________________Date:__ __/__ __/__ __

General Health Questions (Please explain "yes" answers below.)

Has/does the participant:

#	Question	Yes	No
1.	Had any recent injury, illness or infectious disease?	❑	❑
2.	Have a chronic or recurring illness/condition?	❑	❑
3.	Ever been hospitalized?	❑	❑
4.	Ever had surgery?	❑	❑
5.	Have frequent headaches?	❑	❑
6.	Ever had a head injury?	❑	❑
7.	Ever been knocked unconscious?	❑	❑
8.	Wear glasses, contacts or eyewear?	❑	❑
9.	Ever had frequent ear infections?	❑	❑
10.	Ever passed out during or after exercise?	❑	❑
11.	Ever been dizzy during or after exercise?	❑	❑
12.	Ever had seizures?	❑	❑
13	Ever had chest pain during or after exercise?	❑	❑
14.	Ever had high blood pressure?	❑	❑
15.	Ever been diagnosed with a heart murmur?	❑	❑
16.	Ever had back problems?	❑	❑
17.	Ever had joint problems?	❑	❑
18.	Plan to bring an orthodontic appliance to camp?	❑	❑
19.	Have any skin problems?	❑	❑
20.	Have diabetes?	❑	❑
21.	Have asthma?	❑	❑
22.	Had mononucleosis in the last 12 months?	❑	❑
23.	Had problems with diarrhea/constipation?	❑	❑
24.	Have problems with sleepwalking?	❑	❑
25.	Have a history of bed-wetting?	❑	❑
26.	Ever had an eating disorder?	❑	❑
27.	Ever had sought professional help with emotional difficulties?	❑	❑

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

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Which of the following has the participant had?

- ❑ Measles
- ❑ Chicken Pox
- ❑ German Measles
- ❑ Mumps
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C

Which of the following immunizations has the participant had?

- ❑ DTP
- ❑ Polio
- ❑ TD (tetanus/diptheria)
- ❑ MMR
- ❑ Measles
- ❑ Mumps
- ❑ Rubella
- ❑ Hepatitis B
- ❑ Varicella (chicken pox)
- ❑ Haemophilus influenza B

Date of last Tetanus shot________________________

Health Care Information

Name of regular or health care facility ________________________________Phone (______) ___ ___ ___-___ ___ ___ ___

Is the participant covered by an insurance plan? ❑ Yes (please describe below) ❑ No

Plan Name: ______________________________ Group Number: ______________________________

Insurance Company address: ____

Name of insured/policy holder: ______________________________Relation to participant: ______________________________

Policy ID number of Social Security number of policy holder: ____

Use this space to provide any additional information about the participant of which the camp should be aware: ______________________________

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Racial/Ethnic Identity

You are not required to answer these questions. If you choose to do so, please mark one of the following racial or ethnic identities:

- ❑ American Indian or Alaska Native
- ❑ Black or African American
- ❑ Hispanic or Latino
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ Asian
- ❑ White