



Day Camper:____ Resident Camper:____ Day Camp Counselor (< age 18):____ Overnight Adult Participant:____
 PLEASE PRINT CLEARLY IN INK OR USE FILLABLE PDF

| | | |
|---|--------------|--------------------------------|
| First Name: | Middle Name: | Last Name: |
| Mailing Address: | | |
| City: | State: | Zip: |
| Home Phone: | Cell Phone: | E-mail: |
| Parent/Guardian Name (Complete for Camper/Day Camp Counselor < age 18 form only) 1. | | Home Phone: Cell Phone: |
| Parent/Guardian Name (Complete for Camper/Day Camp Counselor < age 18 form only) 2. | | Home Phone: Cell Phone: |
| Custodial Care Information: Both Parents: One Parent (Specify): Other: | | |
| Name of Family Physician: | | Phone: |
| Family Medical/Hospital Insurance Carrier (**Please attach a copy of front and back of card): | | Policy or Group No: |
| Family Dental Insurance Carrier: | | Policy or Group No: |

Health Information: Age:_____ Date of Birth:_____

Immunization Record

| Which of the following Immunizations have you had? | Please give dates of all immunizations | Mo./Yr. | Mo./Yr. | Mo./Yr. | Mo./Yr. | Mo./Yr. | Mo./Yr. |
|--|--|---------|---------|---------|---------|---------|---------|
| Measles | Vaccine: | | | | | | |
| Chicken Pox | DTP | | | | | | |
| German Measles | TD (Tetanus/Diphtheria) | | | | | | |
| Mumps | Tetanus | | | | | | |
| Hepatitis A | Polio | | | | | | |
| Hepatitis B | MMR | | | | | | |
| Hepatitis C | Or Measles | | | | | | |
| | Or Mumps | | | | | | |
| | Or Rubella | | | | | | |
| | Haemophilus Influenza B | | | | | | |
| | Hepatitis B | | | | | | |
| | Varicella (Chicken Pox) | | | | | | |

Date of last health examination (must be within past 24 months): _____ Were there any medical problems at the time?

Does participant have any physical, mental or psychological conditions requiring medication, treatment, or other special restrictions or considerations? Yes____ No____ If yes, please state restriction/consideration and reason:

Camp Choson Health History/Medication Form (Reviewed 06/06/18)

Does participant take any prescribed medications or over the counter medications on a regular basis? ____Yes ____No

Fill in the following table for any prescription or over the counter medications your camper will be bringing to camp.

*****All prescriptions/over-the-counter medications MUST be in their original containers*****

| Medication and Dose | Reason for Medication | Please CIRCLE the time of day The camper takes medications* | Prescription or over-the-counter? |
|---------------------|-----------------------|--|--------------------------------------|
| | | Breakfast Lunch Dinner Bedtime Other | |
| | | Breakfast Lunch Dinner Bedtime Other | |
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| | | Breakfast Lunch Dinner Bedtime Other | |

***Please note: we can only administer prescription medications according to directions on the label, unless we have a signed doctor's note.**

OVER THE COUNTER MEDICATIONS

Check all items that we may give your camper/counselor, if she/he should need medication while at camp. All medications are given based on your individual child's weight or age as listed in the instructions

| | |
|-----------|--|
| | Acetaminophen (such as Tylenol or other non-aspirin pain reliever) |
| | Ibuprofen (Motrin, Advil) |
| | Throat Lozenges |
| | Antihistamine (such as Benadryl) |
| | Antibiotic Ointment (such as polysporin or Neosporin) |
| | Antacid (Tums) |
| | Hydrocortisone cream |
| | Bug spray (contains DEET) |
| | Antifungal Ointment or Spray (for athlete's foot) |
| | Sunscreen (spf 30 max) |
| | Calamine, Caladryl or other anti-itch lotion |
| Comments: | |

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|---|
| Is participant restricted or limited from participating in any physical activity? Yes__ No__ If yes, please explain: |
| Please provide a record of past medical treatment, if any, including injuries or surgeries: |
| Participant has the following health conditions/allergies: ADHD__ Asthma__ Diabetes__ Headaches__ Seizures__ Other:_____ |
| Allergies (specify):_____ Anaphylaxis? Yes__ No__ |
| Participant has the following dietary restrictions: Lactose__ Vegetarian__ Gluten-Free__ Peanut/Tree Nut__ Other_____ |
| Emergency Contact (non-parent): |
| Home/Work Phone: _____ Cell Phone: _____ |
| Relationship: |
| Participation Waiver: <i>I will assume the inherent risk associated with participation in all camp activities. I agree to hold harmless the Girl Scouts of Minnesota and Wisconsin River Valleys, the St. Croix Valley Korean-American Cultural Society, Inc. /dba Camp Choson, staff, counselors, and other designated volunteers from any and all losses and/or accidents, however caused, and agree to release all parties involved from claim or damage that may arise as a result of such loss or accident</i> |
| PARENT/GUARDIAN AUTHORIZATION This health form is complete and accurate. I know of no reason(s), other than the information indicated on this form, why my daughter/son should not participate in the prescribed activities except as noted. In the event that my daughter/son needs medical attention while participating in Camp Choson activities at Camp Lakamaga Girl Scout Camp, I authorize the adult in charge to see that my daughter/son receives routine healthcare, medications, reasonable first aid and to transport my child to a health care facility for emergency services as needed. I give permission for photos/videos to be taken of my camper by the Camp Choson Photographer(s). Signature of parent/guardian: _____ Date: _____ |
| OVERNIGHT ADULT PARTICIPANT/VOLUNTEER AUTHORIZATION This health history is complete and accurate. I am able to engage in all prescribed activities, except as noted. Signature of adult participant: _____ Date: _____ |