캠프 조선 CAMP CHOSŎN

Camp Choson Health History/Medication Form (Reviewed 01/28/2024)

1. Day Camper:____ Resident Camper:____ Day Camp Counselor (< age 18):____ Resident Camp Volunteer:____
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						

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	Haemophilus Influenza B						
	Hepatitis B						
	Varicella (Chicken Pox)						
	COVID-19						

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

_____

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_____

Does the 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:

_____

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_____

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_____

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_____

2. Does the 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	
		Breakfast Lunch Dinner Bedtime Other	
		Breakfast Lunch Dinner Bedtime Other	
		Breakfast Lunch Dinner Bedtime Other	
		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.***

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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:	

Is the 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 will assume the inherent risk associated with participation in all camp activities. I agree to hold harmless The Association Retreat Center, 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*

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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 The Association Retreat Center, 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.

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:_____