SUMMER CAMP CAMPER HEALTH FORM COMPLETE THIS FORM ONLINE AT WWW.OOTBAY.COM

A PARENT OR GUARDIAN MUST COMPLETE AND SIGN THIS FORM. THE DIRECTORS, HEALTH COORDINATOR AND CAMP COUNSELORS WILL HOLD INFORMATION FROM THIS FORM CONFIDENTIAL. THE INTENT OF THIS FORM IS TO PROVIDE THE CAMP DIRECTOR AND HEALTH COORDINATOR THE INFORMATION NEEDED TO PROVIDE APPROPRIATE EMERGENCY CARE. KEEP A COPY OF THIS FORM FOR YOUR RECORDS. ATTACH ADDITIONAL PAGES OR DESCRIPTIONS AS NEEDED. PROVIDE CHANGES TO THIS FORM TO THE HEALTH COORDINATOR AT CHECK- IN ON THE FIRST DAY OF CAMP. PLEASE PRINT LEGIBLY.

CAMPER'S NAME: _____________________________________ GENDER: _________ NICKNAME: __________________ BIRTHDATE: _______________

PARENT/ GUARDIAN'S NAME: __________________________________ EMAIL ADDRESS: _____________________________

PARENT/ GUARDIAN HOME PHONE #:_____________________ WORK PHONE #:_____________________ CELL PHONE #:______________________

IN CASE OF AN EMERGENCY OR IF WE NEED TO GIVE IMPORTANT INFORMATION TO PARENTS, BUT WE CANNOT REACH PARENTS WHO SHOULD WE CONTACT?
EMERGENCY CONTACT PERSON: ____ RELATION TO CAMPER: _____________________
HOME PHONE #:____________________________ WORK PHONE #:___________________________ CELL PHONE #:____________________________

ALLERGIES: LIST ALL KNOWN ALLERGIES, DESCRIBE YOUR CHILD'S REACTION AND THE BEST MANAGEMENT OF THE REACTION; USE EXTRA PAPER IF NEEDED.
MEDICATION ALLERGIES: ____
FOOD ALLERGIES: ____
OTHER ALLERGIES: ____

PAYING FOR HEALTHCARE: THERE IS USUALLY NO CHARGE FOR HEALTHCARE PROVIDED BY OOTB EMPLOYEES, VOLUNTEERS, OR DESIGNEES. YOU ARE FINANCIALLY RESPONSIBLE FOR HEALTHCARE PROVIDED BY ALL OTHER PROVIDERS.

INSURANCE INFORMATION:
HEALTH INSURANCE COMPANY: ________________________________ GROUP #: ______________________ POLICY #: ___________________________

HEALTHCARE PROVIDERS' INFORMATION:
NAME OF PHYSICIAN: ________________________________ OFFICE PHONE #:________________________________
NAME OF DENTIST: __________________________________ OFFICE PHONE #:________________________________
NAME OF PHARMACY: ________________________________ OFFICE PHONE #:________________________________

DIET AND NUTRITION:
____ EATS A REGULAR, VARIED DIET AND IS PREPARED TO EAT A VARIETY OF FOODS WHILE AT CAMP.
____ Is A VEGETARIAN OF THIS TYPE:
____ SEMI- VEGETARIAN (NO PORK OR BEEF) ____ PESCO (NO PORK, BEEF, OR CHICKEN)
____ LACTO (NO MEATS, FISH, SEAFOOD, OR EGGS) ____ OVO (NO MEATS, FISH, SEAFOOD, OR DAIRY)
____ LACTO- OVO (NO BEEF, PORK, CHICKEN, SEAFOOD, OR FISH) ____ VEGAN (NO MEATS, SEAFOOD, EGGS, OR DAIRY)
___ DOES NOT EAT: __________________________________

IMMUNIZATION HISTORY:
DO YOU ATTEST THAT ALL IMMUNIZATIONS REQUIRED FOR SCHOOL ARE UP TO DATE FOR THIS CAMPER? ___ YES ___ NO
If you answered "No" please sign the following statement: *"I understand and accept the potential risks to one who is not fully immunized."*
Signature of parent/ guardian: ______________________________ Date: ___________

MEDICAL HISTORY:
____HAS NO CHRONIC HEALTH CONCERNS
___ HAS THE FOLLOWING CHRONIC HEALTH CONCERNS
____ ASTHMA ____ HEADACHES, MIGRAINES ____DIABETES ____ FAINTING
____SEIZURE DISORDER ____ DYSMENORRHEA ____ BED WETTING ____ DEPRESSION
DESCRIBE ANY OTHER PAST OR CURRENT INJURY, ILLNESS, DISEASE, TREATMENT, SURGERY, OR AFFLICTION THE CAMP SHOULD KNOW IN CASE OF EMERGENCY ____

MEDICATIONS: WILL YOU BE PROVIDING ANY OVER- THE- COUNTER MEDICATIONS OR PRESCRIPTION MEDICATIONS FOR YOUR CAMPER? ___ YES ___ NO
(if yes please complete the medication authorization form on back of form and the supplemental medication authorization form if applicable)

FIRST AID: OOTB EMPLOYEES, VOLUNTEERS, AND DESIGNEES HAVE PERMISSION TO PROVIDE ROUTINE FIRST AID INCLUDING APPLICATION OF:
___ HYDROCORTISONE CREAM ____ NEOSPORIN ____ CALAMINE LOTION ____ TECNU

I VERIFY THAT THE INFORMATION ON THE HEALTH FORM IS CORRECT AND COMPLETE. THIS FORM MAY BE COPIED FOR CAMP RECORDS AND OFFSITE TRIPS. I UNDERSTAND AND ACCEPT THAT OOTB EMPLOYEES, VOLUNTEERS, AND DESIGNEES ARE NOT RESPONSIBLE FOR ANY EFFECTS OF THE FIRST AID GIVEN.
SIGNATURE OF THE PARENT/ GUARDIAN:___________________________________ DATE: ____________

Medication Authorization Form Occohannock on the Bay Camp and Retreat Center

Over- the- Counter and Prescription Medications

OFFICE: (757) 442-7836 FAX: (757) 442-3030

I, _________________________, parent/guardian of ________________________, give the staff of Occohannock on the Bay Camp and Retreat Center (OOTB) permission to administer the following prescribed medications and over- the- counter medications to my child during program hours.

I agree to provide the medication to the camp in the original container labeled with the camper's name, physician's name, name of the medication, the amount and time it is to be given, with the label intact.

I have been provided patient information on these medications by the pharmacist that filled the prescription and I am aware of the possible side effects of these medications. I understand and accept that OOTB is not responsible for any side effects of the medication administered.

I understand and accept that I will not hold OOTB or its employees, volunteers, or designees responsible for any negative outcomes from self-administration of any inhaled asthma medications, nasal sprays, and/ or topical creams.

Also, please note that OOTB does NOT administer any over- the- counter medications/ prescription medications that are not in the original container, expired, or provide any dosage that exceeds what is recommended on the container, unless a doctor's signature is provided. OOTB will also follow what is stated on the prescription label unless a doctor's note is provided stating that there has been a change in the prescription.

List all known allergies and known reactions: ____

Prescription and Regularly Scheduled Medications:	**As Needed Medications:**
Name of medication: ____________________________ Dosage: _______________________________________ Time of Administration: _________________________ Purpose of Medication: __________________________ Name of Prescribing Physician: __________________ Physician Phone: _______________________________	Name of medication: ____________________________ Symptoms needed for administration: (please check all that apply) HEADACHE_______ MUSCLE PAINS_______ STOMACHACHE_______ PAIN_______ CRAMPS_______ OTHER:__________________ Frequency to be administered: ____________________ Dosage: ____
Name of medication: ____________________________ Dosage: _______________________________________ Time of Administration: _________________________ Purpose of Medication: __________________________ Name of Prescribing Physician: __________________ Physician Phone: _______________________________	Name of medication: ____________________________ Symptoms needed for administration: (please check all that apply) HEADACHE_______ MUSCLE PAINS_______ STOMACHACHE_______ PAIN_______ CRAMPS_______ OTHER:__________________ Frequency to be administered: ____________________ Dosage: ____
Name of medication: ____________________________ Dosage: _______________________________________ Time of Administration: _________________________ Purpose of Medication: __________________________ Name of Prescribing Physician: __________________ Physician Phone: _______________________________	Name of medication: ____________________________ Symptoms needed for administration: (please check all that apply) HEADACHE_______ MUSCLE PAINS_______ STOMACHACHE_______ PAIN_______ CRAMPS_______ OTHER:__________________ Frequency to be administered: ____________________ Dosage: ____

With my signature, I understand and accept that OOTB employees, volunteers, or designees are not responsible for any effects of the medications administered. I agree to furnish the said medications in the ORIGINAL container supplied by the pharmacy with the label intact.

Parent/Guardian Signature: ________________________ Date: ________ Home________________ Cell _____________

If you have a medication that exceeds the recommended dosage or there has been a change in the prescription, but not on the label, please have a physician fill out the Supplemental Medication Authorization form