HEALTH PROFILE Page 1 of 3

Make a copy for your files, then MAIL to the address below a minimum of **14 days prior** to the start of the camp session.

Faxed copies WILL NOT be accepted.

DUBOIS CENTER
2651 QUARRY ROAD; DUBOIS IL 62831

Camp Session #_____ Camp Session Date_____

Camper or Staff Name_____
Last First MI

Name Camper/Staff Member Goes By:_____

❑ Male ❑ Female Birth Date_____ Age at Camp_____
month / day / year

INSTRUCTIONS: (If additional space is needed, use back side of page 3 or attach additional pages.)

1) *Complete one form per camper or staff member using dark ink – dark blue or black. Please PRINT.*
2) *Make a copy for your files and MAIL the original to the address above. Faxed copies WILL NOT be accepted.*
3) *Bring the copy with you to camp on the first day of your camp session – just in case.*

Camper / Staff Home Address_____
Street Address City State Zip Code

Parent / Guardian with legal custody to be contacted in case of illness or injury (#1):

Name_____ Preferred Phone #1 (_____) _____

Relationship to Camper /Staff_____ Preferred Phone #2 (_____) _____

Parent / Guardian with legal custody to be contacted in case of illness or injury (#2):

Name_____ Preferred Phone #1 (_____) _____

Relationship to Camper /Staff_____ Preferred Phone #2 (_____) _____

Additional contact – if parents / guardians cannot be reached:

Name_____ Preferred Phone #1 (_____) _____

Relationship to Camper /Staff_____ Preferred Phone #2 (_____) _____

ALLERGIES: ❑ No Known Allergies ❑ Allergic to: ❑Food ❑Medicine ❑Environment (insect stings, hay fever, etc.) ❑Other
(Please list specific allergies and the reaction seen.)

DIET & NUTRITION: ❑ Eats a regular diet. ❑ Eats a regular vegetarian diet. ***(List specifics below.)*** ❑ Eats a vegan diet.
❑ Has special food needs. ***(List specifics below.)***

If significant modifications to a typical camp diet are needed, please contact DuBois Center directly at 618.787.2202.

MEDICATION AUTHORIZATION: The non-prescription, OTC (over-the-counter) medications and treatments listed below may be stocked in the camp Health Center and used as needed to manage illness and injury. Generic forms of these are often used.

Please indicate below your preference for the administration of the following items.

Check YES or NO: ALL of the items on the list may be given: ❑Yes ❑No NONE of the items on the list may be given ❑Yes ❑No
If some items may be given, CHECK the individual items below that MAY be given.

____ Acetaminophen (Tylenol)
____ Ibuprofen (Advil, Motrin)
____ Naproxen / Naproxen Sodium (Aleve)
____ Antihistamine / Allergy medication
____ Cetirizine (Zyrtec) 10 mg
____ Diphenhydramine (Benedryl)
____ Loratadine (Claritin) 10 mg
____ Guaifenesin cough syrup (Robitussin)
____ Generic cough drops
____ Generic sore throat spray
____ Antacid tabs - Calcium carbonate (Tums) 750 mg
____ Bismuth subsalicytate for diarrhea (Kaopectate, Pepto-Bismol)
____ Laxatives for constipation – Magnesium 500 mg (Phillips)
____ Aloe
____ Antibiotic cream
____ Calamine lotion
____ Hydrocortisone 1% cream
____ Insect repellant
____ Sun screen
____ Swim-EAR
____ Tolnaftate for athlete's foot (Tinactin)

IMMUNIZATION HISTORY:

Date of Last Tetanus (DTP, TP, T) shot (month/year) _____ Are the camper/staff member's immunization up to date ❑Yes ❑No

If the camper / staff member HAS NOT BEEN FULL IMMUNIZED, please sign the following statement:
I understand and accept the risks to my child / myself from not being fully immunized.

Signature of Custodial Parent/Guardian, Adult Participant or Staff Member_____ Date_____

Camper or Staff Name _____ Last First MI	Weight _____	**CAMP HEALTH PROFILE** **Page 2 of 3**

MEDICAL INSURANCE INFORMATION: This camper / staff member is covered by private medical / hospital insurance. ❑ Yes ❑ No

Please complete in detail, even if insurance is through a state assisted program.

Insurance Company _____

Group Name _____ Primary Insured _____

Policy Number _____ Insurance Co. Phone Number ( ) _____

HEALTH CARE PROVIDERS for Camper / Staff Member:

Primary Physician(s) _____ Phone ( ) _____

Dentist(s) _____ Phone ( ) _____

Orthodontist(s) _____ Phone ( ) _____

GENERAL HEALTH HISTORY:

For occurrences in the past <u>24 MONTHS</u>, check "Yes" or "No" for each statement. Explain "Yes" answers.
Has / does the camper or staff member:

❑Yes ❑No Been hospitalized? Details: _____

❑Yes ❑No Had surgery? Details: _____

❑Yes ❑No Have recurrent/chronic illnesses? Details: _____

❑Yes ❑No Had a recent infectious disease? Details: _____

❑Yes ❑No Had a recent injury? Details: _____

❑Yes ❑No Had a head injury, concussion or passed out? Details: _____

❑Yes ❑No Had asthma/wheezing/shortness of breath? Details: _____

❑Yes ❑No Have diabetes? Details: _____

❑Yes ❑No Had seizures? Details: _____

❑Yes ❑No Had severe or frequent headaches? Details: _____

❑Yes ❑No Had fainting spells or dizziness? Details: _____

❑Yes ❑No Been dizzy or had chest pain during exercise? Details: _____

❑Yes ❑No Have bone or joint problem or injury or scoliosis? Details: _____

❑Yes ❑No Have ear or hearing problems? Details: _____

❑Yes ❑No Wear glasses, contact, or protective eyewear? Details: _____

❑Yes ❑No Had mononucleosis during the past 12 months? Details: _____

❑Yes ❑No If female, have problems with periods / menstruation? Details: _____

❑Yes ❑No Have problems with falling asleep / sleepwalking? Details: _____

❑Yes ❑No Have a history of bedwetting? Details: _____

❑Yes ❑No Have problems with diarrhea or constipation? Details: _____

❑Yes ❑No Had back, joint or muscle problems? Details: _____

❑Yes ❑No Have any skin problems? Details: _____

❑Yes ❑No Traveled outside the country in the past 9 months? Details: _____

❑Yes ❑No Have other health issues? Details: _____

❑Yes ❑No Been treated for attention deficit disorder (ADD) or attention deficit / hyperactivity disorder (ADHD) Details: _____

❑Yes ❑No Been treated for emotional or behavioral difficulties or an eating disorder? Details: _____

❑Yes ❑No During the past 12 months, seen a professional to address mental or emotional health concerns? Details: _____

❑Yes ❑No Had a significant life event that continues to affect the camper's / staff member's life? (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others) Details: _____

What Have We Forgotten to Ask? In the space below, please provide any additional information about the camper's / staff member's health that you think important or that may affect the individual's ability to fully participate in the camp program. ***Attach additional page if needed.***

CAMP HEALTH PROFILE **Page 3 of 3**	Camper or Staff Name_____ Last First MI	Birth Date _____ month / day / year

MEDICATION: ❑ The camper / staff member WILL NOT take daily medication while attending camp.
❑ This camper / staff member WILL take daily medication(s) while at camp. ❑ **Additional Medication Sheet is attached.**

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies.
All medications are to be turned in to the Health Care Staff when checking-in and must be in ***the original package or prescription container.***

Name of Medication	Date Started	Reason for Taking	When Given	Dosage	How Given
			❑ Breakfast ❑ Supper ❑ Lunch ❑ Bedtime ❑ Other:_____		
			❑ Breakfast ❑ Supper ❑ Lunch ❑ Bedtime ❑ Other:_____		
			❑ Breakfast ❑ Supper ❑ Lunch ❑ Bedtime ❑ Other:_____		
			❑ Breakfast ❑ Supper ❑ Lunch ❑ Bedtime ❑ Other:_____		
			❑ Breakfast ❑ Supper ❑ Lunch ❑ Bedtime ❑ Other:_____		

PERMISSION FOR PARTICIPATION IN CAMP ACTIVITIES:
There are challenges inherent with participation in any camp activity, including but not limited to archery, boating, challenge course, crafts, games, hiking, horseback riding, nature activities, swimming, wagon rides and work projects. I understand that these challenges, which contribute to the unique character and desirability of the activities involved, pose the possibility of severe injury, illness or death. I further understand that many of these activities take place in an outdoor environment. For this and other reasons, I understand the challenges often cannot be eliminated, altered, or controlled. I give permission for myself and/or my child to participate in all camp activities, including but not limited to those described above. I acknowledge and assume the risks involved in these activities, and for any damage, illness, injury, or death resulting from such risks, for myself and/or my child. There are no physical, emotional or mental problems or limitations associated with my child's or my participating in camp activities, except as disclosed by me in writing to DuBois Center. I have read and understand the above, and agree to the terms of this waiver.

Signature of Custodial Parent/Guardian,
Adult Participant or Staff Member_____ **Date**_____

RESTRICTIONS: I have reviewed the program and activities of the camp and feel the camper / staff member can participate:
❑ without restrictions ❑ with the following restrictions or adaptations. ***(Please describe below.)***

ACTIVITY RESTRICTIONS:_____

_____

_____

_____

PARENT / GUARDIAN AUTHORIZATION FOR HEALTH CARE:
This health history is correct and accurately reflects the health status of the camper/staff member to whom it pertains. The person described has permission to participate in all camp activities expect as noted by me and/or the examining physician. I give permission to the camp staff to provide first aid and routine health care to my child to the level of their training and authority. I give permission to medical personnel authorized by camp staff to order x-rays, routine tests and treatment related to the health of the person described for both routine care and in emergency situations, and to hospitalize, secure proper treatment for, order injections, anesthesia, or surgery for this individual. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the camp's staff about my child's health status.

Signature of Custodial Parent/Guardian,
Adult Participant or Staff Member_____ **Date**_____

Make a COPY to keep for your records, and bring it to camp with you on check-in day… just in case. **REV 05-17 - SSXX2**