USGTC Summer Camps

2018 Resident Health Form

Return by June 1 to
USGTC Summer Camp
PO Box 4088
Tequesta, FL 33469

- Completed form must be in our office (address above) at least four weeks before the camper arrives.
- Form must be completed by a custodial parent/guardian.
- USGTC requires that all campers provide documentation of a physical examination by a health care provider within twenty-four months preceding the opening of camp.
- Keep a copy of the completed form; notify our health care service of changes in writing.
- Our healthcare and leadership staff have access to this information.
- We strive to make your child's camp experience a positive one. To accomplish this, we must first determine the adequacy of our facilities to meet the specific needs of your camper. ***If your child has a health issue, it is crucial to receive this information by June 1st prior to your child's arrival to provide a supportive environment and to review your physician's recommendations.***
- Questions? Call - 561-743-8550

Parents Please Complete Pages 1 – 3 & 5

Health Care Provider Completes Page 4 & Non-Prescription Med Form

Return Health Form by June 1

VALIDATION OF HEALTH HISTORY AND PERMISSION TO ENGAGE IN ACTIVITIES

As the parent or guardian of the above named camper, I do hereby confirm that the health information provided is accurate and honest. Therefore, the person herein described has permission to engage in all prescribed camp activities except as noted. ****If for religious reasons you cannot sign this, camp should be contacted for a legal waiver, which must be signed for attendance.***

Family Information

Camper Name_____
Last First Middle

Male ☐ Female ☐ Age as of 6/1:_____ Birth Date _____
Month Day Year

Custodial Parent/ Guardian: (circle one) BOTH PARENTS FATHER MOTHER

OTHER_____

Parent (Father)/Guardian:
Full Name_____

HOME Address _____

City_____ State_____

Zip_____ Country_____

Home Tel._____ Business Tel._____

Cell Tel._____ FAX/email_____

SUMMER Address_____

City _____ State_____

Zip _____ Country_____Summer Tel_____

Parent (Mother)/Guardian:
Name_____

HOME Address _____

City_____ State_____

Zip_____ Country_____

Home Tel._____ Business Tel._____

Cell Tel._____ FAX/email_____

SUMMER Address_____

City _____ State_____

Zip _____ Country_____Summer Tel_____

Emergency Contacts: If we cannot reach you in an emergency, provide contact information for other people who know your camper and with whom we can consult. We assume you have spoken to these emergency contacts and they are willing to assist if the need arises.

1. Name_____ Telephone_____
2. Name_____ Telephone_____

*****Parent/Guardian MUST SIGN The Following Emergency Care Authorization For Attendance*****

EMERGENCY CARE AUTHORIZATION FOR HEALTH CARE

This health history is correct and accurately reflects the health status of the camper to which it pertains. I hereby give permission to the medical personnel selected by USGTC Summer Camps:

- To order X-rays, routine diagnostic tests, treatment;
- To release any records necessary for treatment, referral, billing, or insurance purposes; and
- To provide or arrange necessary related transportation for me/or my child.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by USGTC Camp to secure and administer treatment, including hospitalization, for the person named above. I understand the information on this form will be shared on a "need to know" basis with the USGTC Camp staff. I give permission to photocopy this form for use out of camp. In addition, USGTC Camps 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 USGTC Camps' staff about my child's health status.

X_____
Signature of custodial parent or guardian **Date**

Camper Name:_____

Health Care Providers and Insurance

Health Insurance coverage is required for each camper. ***Please include a copy of your insurance card; copy both sides of the card****.*

Name of Primary Care Provider_____ Tel_____

Name of Dentist/Orthodontist_____ Tel_____

Health Insurance Company_____ Tel_____

Name of Policy Holder_____ Policy Number_____ Group Name/Number_____

Camper Health History – Parent/Guardian Complete

Allergies: **Check all that apply to this camper. Attach additional information on separate sheet if needed.**

☐ **This camper has NO KNOWN ALLERGIES.**

☐ **This camper is ALLERGIC to this FOOD(s):**_____

Causes *anaphylaxis? ☐ **YES** ☐ **NO**

Describe typical reaction_____

Describe treatment_____

☐ **This camper is ALLERGIC to this MEDICATION(s):**_____

Causes *anaphylaxis? ☐ **YES** ☐ **NO**

Describe typical reaction_____

Describe treatment_____

☐ **This camper is ALLERGIC to the following, e.g. environmental, animals, etc.:**_____

Causes *anaphylaxis? ☐ **YES** ☐ **NO**

Describe typical reaction_____

Describe treatment_____

Nutrition: **Check all that apply to this camper. Our kitchen prepares a menu with variety; be sure your camper is ready to explore various foods. We can work with some medically prescribed diets but do not cater to individual food preferences. Call if you have questions.**

☐ **This camper eats a regular diet.**

☐ **This camper is the following type of vegetarian.**

☐ Semi-vegetarian (no pork or beef)
☐ Lacto-ovo (no beef, pork, chicken, seafood or fish)
☐ Pesco (no pork, beef or chicken)
☐ Vegan (no meats, seafood, eggs or dairy)

☐ **This camper does not eat pork because of faith beliefs.**

☐ **This camper is lactose intolerant. Note: our expectation is that the camper self-manages using products such as Lactaid.**

☐ **This camper has Celiac Disease. Note: our expectation is the parent will speak with the Food Service Manager regarding specific diet.**

Chronic or Life-Threatening Health Concerns: **Check all that apply to this camper.**

☐ **This camper has NO CHRONIC or LIFE-THREATENING health concerns.**

☐ **This camper has the following CHRONIC health concerns. Attach additional information if needed.**

Health Concern	Comments – Treatments & approximate dates	Health Concern	Comments – Treatments& approximate dates
☐ Asthma/Respiratory Disorder	_____	☐ Frequent Colds	_____
☐ Bedwetting	_____	☐ Frequent Ear Infections	_____
☐ Bleeding Disorder	_____	☐ Headaches	_____
☐ Cardiac Disorder	_____	☐ Hospitalizations/Surgery	_____
☐ Chronic Illness	_____	☐ Metabolic Disorder/Diabetes	_____
☐ Digestive Disorder/Diet Restriction	_____	☐ Neurological Disorder/Seizures	_____
☐ Eating Disorder/Compulsions	_____	☐ Orthopedic Disorder/Activity Restriction	_____
☐ Encopresis/Constipation	_____	☐ Throat Disorder/Speech Deficit	_____
☐ Fainting	_____	☐ Other	_____

Camper Name:_____

*Immunizations: Please record the dates (month/year) of basic immunizations and most recent booster.

Immunizations	Date(s): Month(s) & Year(s)					
DPT (Diptheria, Pertussis, Tetanus)						
Td (Tetanus)						
TdaP (Tetanus,Pertussis)						
OPV/IPV (Polio)						
MMR (Measles, Mumps, Rubella)						
Hib (Haemophilius Influenza Type B)						
Hepatitis B						
PPD/Mantoux (Tuberculosis)						
Varicella (chicken pox)						
Meningitis						
Other						

***If your camper has not been immunized, please explain why and/or attach supporting documentation.**_____

General History: Check "True" or "False" for each statement.

1. **This camper has had chicken pox or has received varicella immunization**…… ☐ **True** ☐ **False**
2. **This camper has NOT had MONONUCLEOSIS ("Mono") during the past school year**…… ☐ **True** ☐ **False**
3. **This camper's HEARING is within normal ranges**…… ☐ **True** ☐ **False**
4. **This camper's EYESIGHT is within normal ranges or he/she uses corrective lenses to remedy vision**…… ☐ **True** ☐ **False**
5. **This camper typically sleeps without SLEEPWALKING, SNORING, SLEEP TALKING, or making other noises**…… ☐ **True** ☐ **False**
6. **This camper is prepared to FALL ASLEEP AT NIGHT without supports such as reading or listening to music**…… ☐ **True** ☐ **False**
7. **This camper is free of illness, injury or physical challenges that would effect program participation**…… ☐ **True** ☐ **False**
8. **For GIRLS: this camper knows about MENSTRUATION and/or has a normal menstrual history**…… ☐ **True** ☐ **False**
9. **This camper has been in countries OUTSIDE THE UNITED STATES in the past nine (9) months**…… ☐ **True** ☐ **False**
   If "True", list the countries and the length of time spent in each.

   Country_____ Country_____
   Dates_____ Dates_____

10. **Had a recent injury? If yes, please explain**_____

Mental, Emotional and Social Health: Check "Yes" or "No" for each statement.

1. **This camper has been diagnosed with Attention Deficit Disorder (ADD) or AD/HD**…… ☐ **Yes** ☐ **No**
2. **This camper has a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder**…… ☐ **Yes** ☐ **No**
3. **This camper has an emotional health concern (specify**_____**)** ☐ **Yes** ☐ **No**
4. **During the past academic year, this camper has seen or is currently seeing a professional to address mental/emotional concerns**…… ☐ **Yes** ☐ **No**

   If "yes" was the answer to any of the four statements above, attach a statement from your camper's professional (e.g. psychiatrist, physician) that addresses the following three things:
   (a) Describes the concern and the camper's management plan (including medication) while in our program;
   (b) Describes the behaviors that will indicate to our staff that your camper needs professional referral; and,
   (c) Provides a recommendation for the camper's participation in the USGTC Camp program.

5. **This camper has had a significant life event that continues to affect the camper's life** …… ☐ **Yes** ☐ **No**

   If "yes", please provide written information about the event – death of a loved one, adoption, new sibling, survived a disaster – it's impact upon your camper's life, and care tips for the camper's cabin counselor(s). Remember, counselors are generally college students. If "yes" was the answer to any of the four statements above, attach a statement from your camper's professional (e.g. psychiatrist, physician) .

Physical Examination Completed by a Licensed Provider

I have examined (Patient's Name)_____on (Date of Exam) _____.

This child has enrolled in a summer overnight/residential program of USGTC Camp.The program includes physical activity (i.e. 4 hours of gymnastics, tumbling and apparatus training daily) USGTC requires that all campers provide documentation of a physical examination within the twenty-four (24) months preceding the opening of camp. In order to provide proper health supervision while at camp, we ask that the licensed provider advise us of any health concerns, allergies, diet and activity restrictions. Please be specific and attach additional information on a separate sheet if necessary.

Height_____ **Weight**_____ **Pulse**_____ **Respirations**_____ **Blood Pressure**_____

Please indicate, "YES" if patient's examination is *within normal limits* or "NO" if exam is *of concern.* If "NO" is checked, please describe condition.

SYSTEM	YES	NO	COMMENT
General Appearance			
Skin			
Eyes/Vision			
Ears/Hearing			
Nose			
Mouth/Teeth			
Cardiovascular			
Lungs			
Abdomen			
Genitourinary			
Musculoeskeletal			
Neurologic			
Development			
Other			

- **The patient is under the care of a physician for the following reason(s):**_____
  _____
- **Describe the treatment(s) to be continued at USGTC for this patient:**_____
  _____
  _____

ALLERGY HISTORY

- **This patient has allergies. If "yes", please document allergy, typical response and treatment plan below**…… ☐ **YES** ☐ **NO**

ALLERGEN	Typical Reaction	Treatment Plan

RECOMMENDATIONS WHILE AT CAMP

- **This patient <u>DOES HAVE</u> ACTIVITY RESTRICTIONS**…….. ☐ **YES** ☐ **NO**
  Describe_____
- **This patient <u>DOES HAVE</u> DIETARY RESTRICTIONS**…….. ☐ **YES** ☐ **NO**
  Describe_____
- **This patient <u>WILL RECEIVE</u> MEDICATIONS while at camp**…….. ☐ **YES** ☐ **NO**
  (Prescription and/or Over-the-Counter) ***If "YES", please complete the attached <u>Medication Authorization Form</u> (page 5). Please use one form per medication. And complete the Over-the-Counter form with your initials.***
- **<u>ADDITIONAL INFORMATION</u>: We would appreciate any additional information you may have that would help us to provide optimal care for this individual. Attach a separate sheet for additional information, if necessary.**

VALIDATION OF EXAMINATION

In my opinion the above individual may participate in an active camp program with noted restrictions.

Licensed Provider Signature (MD/NP)_____***Date***_____

Address_____***City***_____***State***_____***Zip***_____
Country_____***Office Telephone***_____***Fax***_____

USGTC Summer Camps

Medication Authorization Form

Return by June 1 to
USGTC Summer Camp, PO Box 4088
Tequesta, FL 33469

Licensed Provider and Parent/Guardian Responsibility for Prescription Medication, Non-Prescription Medication and/or Food Supplements

- All medications including prescription, over-the-counter medications, allergy injections, food supplements and vitamins shall have a completed Medication Authorization Form on file in order to be administered while at camp.
- All prescription and over-the-counter medications must be received in a properly labeled pharmacy prescription container bearing a current date, appropriate patient's name, drug name, and the prescribing licensed provider's name, as well as the prescribed dosage and administration time or over-the-counter packaging.
- If there are no changes in the administration of a medication as indicated on a properly labled pharmacy prescription, a parent or guardian may complete the Medication Authorization Form. With any changes to the presciption, a licensed provider must provide written documentation.
- Any over-the-counter medication can only be administered if the"Non-Prescription medication authorization form" is signed by your physician.The OTC medicatons on this form are stocked at camp.
- All medications shall be authorized by signature by a licensed provider.
- Campers with severe allergies requiring epi-pens should bring 2 pens to camp, one for their gym bag and one for the camp nurse.
- Allergy serums must come with specific instructions from prescribing allergist.

Camp Responsibility

- If the nurse or camp director questions the advisability of dispensing a medication at camp, the camp physician/nurse practitioner is to be consulted. ***All medication shall be collected and stored in their original pharmacy***
- ***Labeled container or over-the-counter packaging in the health center under the supervision of a licensed health care professional.***
- ***All medication shall be taken in the presence of and/or under the supervision of a licensed health care professional.***
- All medication records will be kept to document the dispensation of all medications at camp.
- Every reasonable effort will be made to ensure that all campers receive their medications as scheduled and parent/guardian will be notified of any concerns related to their child's medication administration.
- All medications will be returned to the camper at the end of their camp session or properly disposed of if undeliverable.
- All medications and their administration will be confidential and communicated to appropriate persons on a need-to-know basis.

USGTC Summer Camps Medication Authorization Form

Camper Name_____ **Birth Date** _____
Last First Month/Day/Year

Authorization for Dispensing of Medications

As the parent or guardian of the above named camper, I do hereby authorize the USGTC Camps health care providers to administer my child the medications as indicated below.. ****If there is a change in the prescription, the child's health care provider must provide USGTC with written documentation.***

Parent/Guardian Signature_____

Completed by Licensed Provider, for the prescription medication to be administered at camp.

Name of Licensed Provider_____ **Title**_____

Telephone_____ **Signature**_____

Medication_____

Route of Administration_____ **Dosage**_____

Frequency_____ **Time(s) of Administration**_____

Specific directions or information for administration_____

Special side effects, contraindications, or possible adverse reactions to be observed:
_____

Date of order_____ **Discontinuation Date**_____**Diagnosis**_____

Any other medical conditions or medications?_____

Medication_____

Route of Administration_____ **Dosage**_____

Frequency_____ **Time(s) of Administration**_____

Specific directions or information for administration_____

Special side effects, contraindications, or possible adverse reactions to be observed:
_____

Date of order_____ **Discontinuation Date**_____**Diagnosis**_____

Any other medical conditions or medications?_____

Medication_____

Route of Administration_____ **Dosage**_____

Frequency_____ **Time(s) of Administration**_____

Specific directions or information for administration_____

Special side effects, contraindications, or possible adverse reactions to be observed:
_____

Date of order_____ **Discontinuation Date**_____**Diagnosis**_____
Any other medical conditions or medications?_____