

SCYR Medical History/Consent Form

IMPORTANT: This form must be completed and returned before your camper can attend SCYR summer camp. A physical examination is not necessary before attending camp. Camper's medical history must be current (updated forms are needed annually, even for returning campers).

CAMPER INFORMATION

First Name: _____ Middle: _____ Last: _____
 Sex: Female Male Date of Birth ____/____/____ Age at start of camp session ____
 Mailing Address: _____ Physical Address: _____
 City: _____ State: ____ Zip: _____ Social Security # ____-____-____

EMERGENCY CONTACT

Parent/Legal Guardian #1 Name: _____
 Home Phone: (____) ____-____ Work Phone: (____) ____-____ Cell: (____) ____-____
Parent/Legal Guardian #2 Name: _____
 Home Phone: (____) ____-____ Work Phone: (____) ____-____ Cell: (____) ____-____
If parent/guardian cannot be reached in an emergency, notify: _____
 Home Phone: (____) ____-____ Work Phone: (____) ____-____ Cell: (____) ____-____
 Child's Primary Physician: _____ Phone (____) ____-____
 Child's Dentist/Orthodontist: _____ Phone (____) ____-____

VACCINES		Year/Month	Year/Month	Year/Month	Year/Month		Date
DTP or Td	Vaccine						
Tetanus	Vaccine						
Oral Polio	Vaccine						
Measles	Vaccine					Illness	
Mumps	Vaccine					Illness	
Rubella	Vaccine					Illness	
Hepatitis A	Vaccine					Illness	
Hepatitis B	Vaccine					Illness	
Hepatitis C	Vaccine					Illness	
Varicella/Chicken Pox	Vaccine					Illness	
Haemophilus Influenza B	Vaccine						
TB Mantoux Test	Date of last test ____/____/____ <input type="checkbox"/> Positive <input type="checkbox"/> Negative						

ALLERGIES

Please list all known allergies. Describe allergy (food, medicine, environmental, etc.), reaction to allergen, and management of reaction: _____

SPECIAL RESTRICTIONS/REQUIREMENTS

Does the participant require any special supervision, restriction (diet, physical activity, behavior, etc), or accommodation? Please explain: _____

Vegetarian meals Vegan meals Other: _____

(over please →)

GENERAL HISTORY (explain “yes answers below):

Has/does the participant:	Yes	No	Has/does the participant:	Yes	No
Had any recent injury, illness or infectious disease?			Ever had problems with joints (e.g., knees, ankles)?		
Have a chronic or recurring illness/condition?			Ever had back problems?		
Ever been hospitalized?			Have an orthodontic appliance being brought to camp		
Ever had surgery			Have any skin problems (e.g., itching, rash, acne)?		
Have frequent headaches?			Have diabetes?		
Ever had a head injury?			Have asthma?		
Ever been knocked unconscious?			Had mononucleosis in the past 12 months?		
Wear glasses, contacts or protective eyewear?			Had problems with diarrhea/constipation?		
Ever had frequent ear infections?			Have problems with sleepwalking?		
Ever passed out during or after exercise?			If female, have an abnormal menstrual history?		
Ever been dizzy during or after exercise?			Have a history of bed-wetting?		
Ever had seizures?			Ever had an eating disorder?		
Ever had chest pain during or after exercise?			Ever had emotional difficulties requiring professional help?		
Ever had high blood pressure?			Ever been diagnosed with a heart murmur?		

Please explain any yes answers:

MEDICATION

Please list all medications (including over the counter or nonprescription drugs) taken routinely. Pack enough medication to last the entire time at camp. Keep medication in the original packaging/bottle identifying the prescribing physician, medication name, dosage, and frequency of administration.

All medications must be turned in to SCYR staff as soon as the camper arrives at camp and/or comes under our care. Campers are not permitted to keep and self-administer medications.

Med #1: _____ Dosage: _____ Specific times taken each day: _____
 Reason for Taking: _____
 Med #2: _____ Dosage: _____ Specific times taken each day: _____
 Reason for Taking : _____
 Med #3: _____ Dosage: _____ Specific times taken each day: _____
 Reason for Taking: _____
 Identify medications taken during the school year that participant does not take during the summer:

INSURANCE

Is the participant covered by medical/hospital insurance?: Yes No

If yes, carrier or plan name: _____ Group #: _____

Please attach a photocopy of health insurance card.

Parent/Guardian Authorizations: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to Sangre de Cristo Youth Ranch (SCYR) staff to provide routine and emergency health care, and administer prescribed medications as listed above. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to SCYR staff to arrange necessary related transportation, and hospitalization for my child. I hereby give permission to the physician(s) selected by SCYR staff to administer necessary treatment, including hospitalization, medications, diagnostic tests, anesthesia, and surgery for my child named above.

Parent/Guardian Signature: _____ Date: ____ / ____ / ____