Claggett Center

2018 Special Challenge Camp Health Information Form

Participant must complete this form and submit it with the camp application. No participant will be permitted to stay at Claggett without the *advance receipt* of the completed and signed form. Please print clearly in ink.

Participant's Full Name: _____

Home Address: _____

Phone:_____ Email:_____

Date of Birth: _____Gender:_____ Age:___

List two Emergency Contacts:

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Name of Personal Physician:_____Phone:_____

Insurance Information: Carrier:_____Plan #: _____

Primary Insured:_____Policy #: _____

Health History Please briefly describe: (Include any issues that may affect or limit full participation in camp)

_____

_____

_____

Allergies? None _____ List **Reaction**

Medications		
Food		
Insects		
Bee Stings		
Plants		
Animals		
Other		

General Health Information: Circle Y or N

Asthma	Y	N	Diabetes	Y	N	High Blood Pressure	Y	N
ADD/ADHD	Y	N	Digestion	Y	N	Kidney Disease	Y	N
Cancer/Leukemia	Y	N	Heart Trouble	Y	N	Lungs	Y	N
Convulsions/Seizures	Y	N	Hemophelia	Y	N	Mental Illness	Y	N
Eyes/Ears/Nose/Throat	Y	N		Y	N	Daily Prescriptions	Y	N

Explain any Yes answers:

_____

_____

May we administer non-prescription meds (check list below)?	Yes	No
Do you take any prescription medications (list them below)?		
Do you have a history of seizures?		
Do you have a history of sleep apnea?		
Do you require plastic sheets?		
Any physical/mobility limitations?		
Any special hygiene needs or history of bed wetting?		
Do you require assistance shaving? *If YES provide prescription from doctor, including frequency.*		
Special Medical Equipment CPAP, Nebulizer, Inhaler? List:		
Do you have a tetanus shot? DATE:		

Participant Name: _____

Are you prone to any of the following? Circle all that apply

Headaches	Sore Throats	Sunburn	Poison Ivy	Colds/Fever
Stomach Aches	Sprains	Nightmares	Swimmer's Ear	Menstrual Cramps

Check which of the following Lotions and/or Ointments may be administered by the nurse?

Antibiotic Ointment	Benadryl Cream	Hydrocortisone Cream
Antifungal Cream	First Aid Cream	Antiseptic Wash
Caladryl Lotion (itch)	Ear Drops (swimmer's ear)	Eye Wash

Check which over-the-counter medications may be administered by the nurse?

Tylenol	Benadryl	Pepto Bismol	Tums/Maalox
Motrin/Advil	Sudafed	Milk of Magnesia	Throat Lozenges/Spray

In case of emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission for Claggett Center, the Center's designee, or the Episcopal Diocese of Maryland to secure proper treatment for the person named on this form, including hospitalization, surgery, anesthesia, or the administration of any medication oral or injected.

I agree to be responsible for all costs associated with such treatment.

Date:_____Signature: _____

Print Full Name:_____

All medications must be checked in with the health care provider at registration.
All medications must be in their ORIGINAL containers with the camper's name and the dosage clearly visible.

Medications must be given as per the directions on the prescription container.
If possible bring medications in Bubble Packs from the pharmacy.

Medication Chart:

	Dosage and Time to Be Given						
Medication	Pre-Breakfast	Breakfast	Lunch	Dinner	Night	Other	As Needed
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
Other Instructions:							