Entomology Camp Health History & Authorization Form 2018

Please print clearly

Camper Name: _____ Age: __ Birth Date:_____ Gender: __ Campers Cell #: _____

Parents/Legal Guardians: _____Cell # 1:_____

Cell # 2:_____

Home Address: _____ City_____ State___ Zip _____

Where can your parents/guardians be reached during camp, or event, if not at above address and phone numbers?

_____

Relatives or friends authorized to act in campers behalf in case of emergency if parents/guardians cannot be reached:

Name: _____Cell #:_____ Name: _____ Cell #:_____

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director or medic to secure proper treatment for, hospitalize, order injections, anesthesia and surgery for my child named above should it be deemed necessary. The camp director has a prescription for adult and youth EpiPens for camp emergencies and they are readily available. I authorize the Camp Director, medic or other staff to administer an EpiPen injection for life threatening allergic reactions.

_____ _____
Parent or Legal Guardian Date

If camper has been exposed to any communicable disease within two weeks before attending an entomology camp, please explain fully in a note to the Director. You may use space on the back of this form.

Name, office and emergency phone number(s) of family physician:

_____

Medications: _____; Depression or behavior issues (circle): Yes No

Allergies (food or medicine), medical conditions, disabilities and special needs:

_____
(asthma or hay fever, ear infections, thyroid disease, Parkinson's, high blood pressure and/or heart disease, convulsions or seizures, poison ivy/oak, penicillin, sulfa, other drugs, food, etc.)

Stings hurt and often there is localized swelling. An allergic reaction to a sting refers to a life-threatening reaction (anaphylaxis) or severe swelling.
Have you ever been stung by bees, ants, wasps, etc.? _____, Which? _____

Did you have an anaphylactic reaction (difficulty breathing or swallowing, severe itching of the eyes, abdominal pain, vomiting, hives, diarrhea, etc.)? _____, What treatment was required? _____
_____ Did you go to a clinic or hospital?_____

Was an EpiPen administered? _____ Do you carry an EpiPen? _____ Do you have any known heart diseases or cardiac problems? _____ Please describe: _____
Diabetes? _____ Circle Type 1 or Type 2. Usual hypoglycemia treatment_____
Do you regularly check your blood glucose level? _____. Do you use/carry glucose tablets? _____. Circle the following answers. Do you use diabetes pills or insulin? If insulin, do you use a pump or injections (pen or syringe)?
Diabetes dietary modifications or restrictions: _____

Shell fish, peanut or other allergies? _____ Please List_____

List activities to be encouraged _____or restricted _____

___ Non Swimmer, ___ Beginner Swimmer, ___ Experienced Swimmer

Immunization Record

Last Year Administered

DPT (diphtheria, pertussis and tetanus) _____
MMR (Measles, Mumps, Rubella) _____
Polio _____
Flu _____
Chicken Pox _____
Hepatitis A or B _____
Exemption to Immunizations (form required)

Date of most recent physical exam_____
Give dates of recent operations or serious injuries _____
Other diseases or details of above _____

Are there any other medical, behavior, etc. issues we should be aware of?_____
_____

If you are bringing medications to the camp, or event, with you, make sure your name is on them and that the Director is advised of the directions for administration. That information should accompany this form.

ATTACH A COPY OF the front and back of current FAMILY MEDICAL INSURANCE card.
Notes:

The information on this form is correct. _____ _____
Parent or guardian, Date **Family physician (optional), Date**

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