

**THE PENNSYLVANIA LIONS BEACON LODGE CAMP: CAMPER HEALTH FORM**

**114 SR 103 SOUTH, MOUNT UNION, PA 17066-9601 PHONE: (814) 542-2511**

**E: Mail [beaconlodgecamp@verizon.net](mailto:beaconlodgecamp@verizon.net) Web site: [www.beaconlodge.com](http://www.beaconlodge.com)**

Camper Name: \_\_\_\_\_ Session Attending: \_\_\_\_\_

DOB: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Male: \_\_\_\_ Female: \_\_\_\_ Return Camper: \_\_\_\_ New Camper: \_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_ Legal Guardian: \_\_\_\_\_

**IN THE EVENT OF AN EMERGENCY, PLEASE NOTIFY:**

NAME: \_\_\_\_\_ RELATION: \_\_\_\_\_ TELEPHONE #(s): \_\_\_\_\_

1. \_\_\_\_\_

2. \_\_\_\_\_

**PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD (S). A NEW COPY IS REQUIRED YEARLY.**

**READ & SIGN BELOW:**

I, hereby certify that the facts set forth in the following application are true and complete to the best of my knowledge. I understand that this application does not constitute an agreement of acceptance. I understand that the Pennsylvania Lions Beacon Lodge Camp's receipt of application materials and its selection of all campers are based upon the accuracy of the information disclosed in the written Registration Form, camper's space availability, and its judgment as to whether the camp's staff can safely manage the child/adult. I understand that any falsified statement on the application or any supplement thereto, shall be considered sufficient cause for dismissal and I release the PA Lion's Beacon Lodge Camp from any liability associated with such dismissal.

I have authorized the physician to give needed immunization and to furnish requested information to agency as needed. In the event of illness or accident in the course of such activity, I request that measures be instituted without delay as judgment of medical personnel dictates.

I understand that my child/adult must adhere to all rules and regulations while attending Beacon Lodge Camp. I release the PA Lion's Beacon Lodge Camp, its Board, Officers, employees, Nursing Staff, Administrative Staff, and counselors of all medical damages.

Camper's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**ACA REGULATIONS AND CAMP POLICY REQUIRE ALL MEDICATIONS TO BE KEPT IN THE INFIRMARIES FOR SAFETY PURPOSES. INHALERS, EPI-PENS, AND CREAMS ARE THE ONLY EXECPTIONS; HOWEVER, THESE ITEMS ARE TO BE CHECKED IN WITH THE NURSING STAFF UPON ARRIVAL!**

**READ & SIGN:** Upon arrival at camp the nurse will collect ALL medications. Be sure all medications are in **original** containers and are clearly labeled with camper's name; name of drug; dosage and medication time schedule. All medications must match doctor's orders upon arrival to camp. If changes are made prior to camp, the camper/guardian must request an additional medication sheet to be filled out by the physician. All medication bottles must be of the current year. Any medication changes made within 2 months of camper's camping session, which may cause a change in behavior or relative health, should be discussed with the Camp Director. I have read, understand, and agree to the rules and regulations of this form.

Camper/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**ATTENTION CAMPERS & CAREGIVERS!!!**

**PLEASE INCLUDE A RECENT PHOTO**

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**TO BE COMPLETED BY A LICENSED PHYSICIAN.**

Please check all information on both sides of the health form. Be sure to include your signature, date, phone number, and address.

Review immunization for youth under 18—tetanus and diphtheria toxoids, measles, mumps & rubella vaccines; trivalent oral polio vaccine are required. **Adults are required to have tetanus booster within 10 years.** All campers SHOULD be immunized for Hepatitis. Camper may be participating in strenuous activity, which could include one or more of the following; athletic competition, hiking, boating, outdoor activities, etc. Campers will spend much of their day in the sun, please note if camper has any sun restrictions.

**MEDICAL HISTORY:**

- 1.  SEIZURES
- 2.  DIABETES:  INSULIN,  NON-INSULIN
- 3.  GLAUCOMA
- 4.  BLIND
- 5.  HEARING IMPAIRED
- 6.  INCONTINENCE
- 7.  ASTHMA/EMPHYSEMA
- 8.  MENTAL RETARDATION:  
 MILD,  MODERATE,  SEVERE,  PROFOUND
- 9.  ADD/ADHD
- 10.  HEART CONDITION
- 11.  BLEEDING D/O
- 12.  ARTHRITIS
- 13.  ALLERGIES
- 14.  DEPRESSION
- 15.  EATING DISORDER: \_\_\_\_\_
- 16.  AUTISM
- 17.  DENTURES
- 18.  PSYCHOLOGICAL DISORDER:  
 \_\_\_\_\_
- 19.  SPINABIFDA
- 20.  BEDWETTING
- 21.  SKIN/GLANDS
- 22.  STOMACH/BOWELS
- 23.  TOILET TRAINED
- 24.  HYPERACTIVE
- 25.  MIGRAINE HEADACHES

Please indicate additional past medical/surgical history:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

ARE YOU AWARE OF ANY CURRENT HEALTH PROBLEMS? \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_  
EYE COLOR: \_\_\_\_\_ HAIR COLOR: \_\_\_\_\_

DATE OF LAST TETANUS: \_\_\_\_\_  
(Must be within last 10 years.)

Date of last Tuberculosis Test: \_\_\_\_\_  
PPD \_\_\_\_\_, Mantoux \_\_\_\_\_, +: \_\_\_\_\_, -: \_\_\_\_\_

**PHYSICIAN'S EVAL & ADVICE FOR CAMPER PARTICIPATION:**

- Can participate in all activities
- Limit activities to: \_\_\_\_\_
- Cannot take part in: \_\_\_\_\_

**Please Initial:** \_\_\_\_\_ I certify the mentioned child/adult has been examined by me and of this date is free of any contagious or infectious disease, and I consider it safe for him/her to attend camp.

Has he/she been immunized against Hepatitis "B"?  
**Yes**  **No**  **Results: +** \_\_\_\_\_ **or --** \_\_\_\_\_

- Medications (prescription) \*list on med sheet
- Medication (over the counter) \*list on med sheet
- Special Diet (attach dietary sheet)**
- Other: \_\_\_\_\_

**EYE HISTORY:**

EYE DISABILITIES: \_\_\_\_\_ BEST-CORRECTED VISION:

1. \_\_\_\_\_ 1. RIGHT EYE: \_\_\_\_\_

2. \_\_\_\_\_ 2. LEFT EYE: \_\_\_\_\_

3. \_\_\_\_\_

DOES CHILD/ADULT WEAR:  GLASSES,  
 CONTACT LENSES,  PROSTHETIC DEVICE

DOES CHILD/ADULT WEAR HEARING AIDES?  
 YES  NO  RIGHT EAR  LEFT EAR

BLOOD PRESSURE: \_\_\_\_\_ PULSE: \_\_\_\_\_

CAN CAMPER AMBULATE?  YES  NO

DOES CAMPER USE A WHEELCHAIR?  YES  NO

DOES CAMPER NEED ONE-ON-ONE ASSISTANCE?  
 YES  NO

CAN CAMPERS SWIM?  YES  NO

**Dr.** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_

**State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Physician's Signature & Date:**

\_\_\_\_\_