

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 Web site: 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: _____

ATTENTION CAMPERS & CAREGIVERS!!!

PLEASE INCLUDE A RECENT PHOTO

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 10years.** 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:
