

HEALTH & MEDICAL INFORMATION

PLEASE ACCURATELY COMPLETE THIS FORM

All medical information will be kept confidential. Signing below gives permission to transmit this information electronically.

NAME: _____ HEIGHT: _____ Feet _____ Inches WEIGHT: _____ lbs

MEDICAL CONDITIONS

Check all that apply

<input type="checkbox"/> Heart/Circulatory <input type="checkbox"/> Difficulty Breathing with Exercise <input type="checkbox"/> Diabetes/Blood Sugar Concerns <input type="checkbox"/> Vision/Hearing/Oral (requiring attention) <input type="checkbox"/> Physical Equipment, Knee/Ankle Braces, Crutches/Walker/Wheelchair <input type="checkbox"/> Abdominal/Digestive Disorder	<input type="checkbox"/> Anxiety/Depression <input type="checkbox"/> Muscular/Skeletal Conditions <input type="checkbox"/> Kidney/Urinary <input type="checkbox"/> Sleep Disorders, Sleepwalking/Night Terrors <input type="checkbox"/> Learning Disability <input type="checkbox"/> Behavioral Concerns <input type="checkbox"/> Lung/Respiratory Asthma	<input type="checkbox"/> Recent Surgeries/Injuries (explain below) <input type="checkbox"/> Seizures/Neurological/Fainting <input type="checkbox"/> Thyroid <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Other: Any Medical Concern Not Listed
--	---	--

CURRENT MEDICAL INFORMATION

Check and describe all that apply

<input type="checkbox"/>	Allergic Reactions <i>All prescribed epi pens should be brought to camp.</i>	Reactions and Severity. <input type="checkbox"/> Hay Fever/Plant Allergy <input type="checkbox"/> Latex/Tape/Adhesive Allergy <input type="checkbox"/> Insect Allergy <input type="checkbox"/> Environments, ie metal/aerosols	Explanation:
<input type="checkbox"/>	Asthma <i>All inhalers should be brought to camp.</i>	Severity <input type="checkbox"/> Exercise Only <input type="checkbox"/> Uses an inhaler occasionally <input type="checkbox"/> Uses inhaler and medication regularly <input type="checkbox"/> Currently under a physician's care	Explanation:
<input type="checkbox"/>	Dietary Allergies	Restrictions <input type="checkbox"/> Gluten Free <input type="checkbox"/> Dairy Free <input type="checkbox"/> Nut Free <input type="checkbox"/> Other (please specify)	Explanation:
<input type="checkbox"/>	Required Daily Medications	List of Medications along with dose and administration. <i>All medications will be submitted in original containers to the camp nurse at the precamp health screening.</i>	

OVER-THE-COUNTER MEDICATIONS

The camp nurse has some medication on-hand for minor ailments. If there is a medication listed that you **DO NOT** want your daughter/son to receive, please checkbox:

- | | | | |
|---|--|---|----------------------------------|
| <input type="checkbox"/> Ibuprofen/Motrin | <input type="checkbox"/> Antihistamine
(Benadryl, Zyrtec, Claritin) | <input type="checkbox"/> Tylenol
(Acetaminophen) | <input type="checkbox"/> Antacid |
|---|--|---|----------------------------------|

This medical history is correct to the best of my knowledge, and the person described herein has my permission to engage in ALL camp activities except as noted in the online form. I understand that I may be required to pick up my daughter from camp if she becomes ill.

Print Name

Signature of Parent or Guardian

Date

IMMUNIZATION RECORD

NAME: _____

WARD: _____

Laws and Regulations Relating to Organized Camps

"30750 Health Supervision"

(a) Every camper and each staff member entering camp shall furnish a health history of his or her health status that is completed and signed by the individual camper or staff member, or by the parent or guardian if the camper or staff member is under the age of 18. This history shall be kept on site as long as the camper or staff member is at camp and shall include the following:

- (1) A description of any health condition requiring medication, treatment, special restrictions or consideration while at camp.
- (2) A record of immunizations including date of last tetanus shot.
- (3) A record of any allergies.

Indicate YES/NO as to whether the camper is immunized. If the camper has had the disease, please indicate. Provide date of immunization or illness. **-OR- PLEASE ATTACH UP-TO-DATE IMMUNIZATION RECORDS.**

YES	NO	HAD DISEASE	IMMUNIZATION	DATE(S)
			Tetanus (DTaP)	
			Pertussis (DTaP)	
			Diphtheria (DTaP)	
			Measles/Mumps/Rubella (MMR)	
			Polio (DTaP)	
			Chicken Pox (Varicella)	
			Hepatitis A (HAV)	
			Hepatitis B (HBV)	
			Meningitis (Meningococcal)	
			Influenza	
			COVID-19 (latest shot or booster)	
			Other (i.e. HIB)	

TREASURE MOUNTAIN CAMP IMMUNIZATION RECORD WAIVER AND RELEASE OF LIABILITY

Rather than complying with the State's Law and Regulations, I am refusing to provide immunization information for the following reason(s):

Print Name

Signature of Parent or Guardian

Date