Health & Safety Information

Camper: ____________________

The Camper's custodial parent or guardian must complete the following information. The intent of this information is to provide the camper's health background to Adventure Science Center staff so they may provide the appropriate health care treatment. Please provide complete information so that the camp can be aware of any camper's special needs. Any changes to this form should be provided to Adventure Science Center personnel upon participant's arrival at camp. The information on this form is not a part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Keep a copy of the completed form for your records.

Name: ____________________

INSURANCE INFORMATION:

(Adventure Science Center does not carry accident or sickness insurance for participants.)

IS THE PARTICIPANT COVERED BY FAMILY MEDICAL/ HOSPITAL INSURANCE? ❑ YES ❑ NO

CARRIER OR PLAN NAME ____________________ **GROUP #** ____________________

ADDRESS ____________________ **CITY** ____________________ **STATE** ______ **ZIP** ______

NAME OF INSURED ____________________ **RELATIONSHIP** ____________________

POLICY HOLDER INSURANCE ID # ____________________ **PHYSICIAN'S NAME** ____________________

PHYSICIAN'S PHONE # ____________________ **HOSPITAL OF CHOICE** ____________________

DOES YOUR CAMPER HAVE ANY MEDICAL CONDITIONS? ❑ YES ❑ NO

(if yes explain in detail) ____________________

DOES YOUR CAMPER REQUIRE SPECIAL MEDICAL TREATMENT? ❑ YES ❑ NO

(if yes explain in detail) ____________________

DOES YOUR CAMPER HAVE SPECIAL RESTRICTIONS? ❑ YES ❑ NO

(if yes explain in detail) ____________________

ROUTINE MEDICATIONS

MED #1 ____________________ **DOSEAGE INSTRUCTIONS** ____________________

MED #2 ____________________ **DOSEAGE INSTRUCTIONS** ____________________

MED. #3 ____________________ **DOSEAGE INSTRUCTIONS** ____________________

WAIVER ACKNOWLEDGEMENT OF MEDICATION PROCEDURES

The Adventure Science Center prefers that all medication be taken at home before arrival and after the camp day. However, if lunchtime medications are required, please send enough medication for the entire week. All medicines must be in the original packaging/ container that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. The Adventure Science Center will collect all medications at the beginning of the camp week, and maintain possession until needed. The camp staff responsible will then re-collect the medication and re-lock it.

MY CHILD TAKES ROUTINE MEDICATIONS ❑ YES ❑ NO

MY CHILD CAN ADMINISTER HIS/HER OWN MEDICATION ❑ YES ❑ NO

MY CHILD NEEDS ASSISTANCE WITH THE ADMINISTERING OF MEDICATION ❑ YES ❑ NO

ALLERGY INFORMATION

MEDICATION ALLERGIES:

____

____

FOOD ALLERGIES:

____

____

OTHER ALLERGIES:

____

____

____

IMMUNIZATION INFORMATION

PLEASE GIVE ALL DATES OF IMMUNIZATION FOR: (OR ATTACH FILES)

VACCINE DATES:	MO/YR	MO/YR	MO/YR	MO/YR	MO/YR	MO/YR
DTP	_____	_____	_____	_____	_____	_____
TD (TETANUS/DIPHTHERIA)	_____	_____	_____	_____	_____	_____
TETANUS	_____	_____	_____	_____	_____	_____
POLIO	_____	_____	_____	_____	_____	
MMR	_____	_____				
OR MEASLES	_____	_____	_____			
OR MUMPS	_____	_____	_____			
OR RUBELLA	_____	_____	_____			
HAEMOPHILUS INFLUENZA B	_____	_____	_____	_____		
HEPATITIS B	_____	_____	_____			
VARICELLA (CHICKEN POX)	_____	_____				

PARENT GUARDIAN AUTHORIZATION

I approve this registration and certify that the camper is capable of such an experience. I agree to pay the balance of the camp fees at least 7 days before the beginning of the reserved camp session. The camp fees are not refundable without a doctor's authorized medical reason. I understand that no refunds are given if a child leaves early for disruptive behavior. I grant permission for the camper to participate in all planned camp activities including off site trips by van or bus, and/or hiking. In case of an accident or illness, the Adventure Science Center is authorized to secure emergency medical treatment. Prudent attempts will be made to contact the camper's legal guardian immediately. I understand that related expenses for this medical attention will be my responsibility. This health form is correct and complete as far as I know, and the person herein described has my permission to engage in all camp activities except as noted.

The Adventure Science Center is not responsible for lost, stolen, or damaged personal articles.

PERMISSION TO PROVIDE NECESSARY TREATMENT OR EMERGENCY CARE

"I hereby give permission to the medical personnel selected by Adventure Science Center to order X-Rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency. I hereby give permission to the physician selected by Adventure Science Center to secure and administer treatment, including hospitalization, of the person named on the form. This completed form may be photocopied."

______________________________	______________________________	______________
SIGNATURE	**PRINTED NAME**	**DATE**