THE PHOEBE NEEDLES CENTER

MEDICAL INFORMATION FORM RESIDENTIAL CAMP

CAMPER'S NAME _____
(first) (middle) (last) (preferred)

Date of Birth _____ Gender Male _____ Female _____

Parent/Guardian's Name _____

Address _____

City, State, Zip Code _____

Daytime Phone Number _____ Evening Phone Number _____

In case of emergency, contact _____ Relationship _____

Primary Phone Number _____ Secondary Phone Number _____

What is the current status of your youth's health? _____

Name of your physician or clinic _____ Phone number _____

Does the child attending camp have health insurance coverage? _____ yes _____ no

Name of company _____ Group/Individual Policy Number _____

Identification Number _____ Phone Number _____

Address _____

Is your youth allergic to bee or wasp stings? _____ yes _____ no If so, will they have medication? _____

List any activities from which your youth should be restricted _____

List any dietary restrictions _____

_____

A NOTE TO PARENTS AND GUARDIANS

In order to further provide for your youth's safety while at camp, we provide an accident and illness policy through the Church Insurance Agency. During the time your youth is attending camp at the Phoebe Needles Center, they will be provided with secondary insurance coverage for medical expenses due to accident or illness. This includes activities on and off the Phoebe Needles Center, Inc. property.

FOR OFFICE USE ONLY (please initial each item)

Check Medications _____ *Check Allergies* _____ *Check Restrictions* _____

GENERAL HEALTH QUESTIONS

Has/does the camper:

1. Had a recent injury, illness, or infectious disease?	Yes	No
2. Have a chronic or reoccurring disease?	Yes	No
3. Have frequent headaches?	Yes	No
4. Wear glasses, contacts, or protective eyewear?	Yes	No
5. Have ear/sinus problems?	Yes	No
6. Ever had frequent infections?	Yes	No
7. Ever passed out during or after exercise?	Yes	No
8. Ever been dizzy during or after exercise?	Yes	No
9. Ever had seizures?	Yes	No
10. Ever had low or high blood pressure?	Yes	No
11. Ever been diagnosed with a heart murmur?	Yes	No
12. Ever have heart disease (CHF, CAD, MI)?	Yes	No
13. Have COPD?	Yes	No
14. Ever have a Stroke/TIA?	Yes	No
15. Ever had back problems?	Yes	No
16. Ever have joint problems (knees, ankles)?	Yes	No
17. Require an orthodontic appliance?	Yes	No
18. Have skin problems (rash, acne, itching)?	Yes	No
19. Have diabetes?	Yes	No
20. Have asthma?	Yes	No
21. Have constipation or diarrhea?	Yes	No
22. Sleepwalk?	Yes	No
23. Sleep disorders? (including bedwetting)	Yes	No
24. Have an abnormal menstrual history?	Yes	No
25. Have an eating disorder?	Yes	No
26. GI problems (Abdominal, digestive)?	Yes	No
27. Have emotional/behavioral difficulties that required professional help?	Yes	No
28. Have ADD or ADHD?	Yes	No
29. Use any type of tobacco products?	Yes	No
30. Had any recent surgery (last year)?	Yes	No

(If yes, please explain on the back of page 3)

ALLERGIES

List any known allergies, or state "NONE" to:

MEDICATIONS: _____

_____

Reactions: _____

Treatment: _____

FOODS: _____

_____

Reactions: _____

Treatment: _____

PLANTS, ANIMALS, ETC.: _____

_____

Reactions: _____

Treatment: _____

OTHER: _____

_____

Reactions: _____

Treatment: _____

COMPLETE ONE OPTION FOR IMMUNIZATION VERIFICATION

OPTION ONE: I, _____ (custodial parent/legal guardian), attest that, _____ (camper), has received **ALL** immunizations required for school, and that these immunizations are up to date as of June 1, 2017.

The date of his/her most recent tetanus shot is _____ (month/year).

OR

OPTION TWO: I, _____ (custodial parent/legal guardian), attest that, _____ (camper), does **NOT** receive immunizations for religious reasons or other reasons.

_____

Signature of custodial parent of legal guardian required for OPTION TWO

MEDICATIONS

All medications (prescription and non-prescription) must be keep in the original container/packing, identifying physician (if prescription), name of medication, dosage and frequency of administration. Bring enough medication to last the entire session of camp. Attach additional pages if needed to list all medications. IF NO MEDICATIONS ARE BEING USED, STATE "NONE."

MEDICATION

Dosage : _____

Frequency: _____

Reason for Taking: _____

_____

MEDICATION

Dosage : _____

Frequency: _____

Reason for Taking: _____

_____

MEDICATION

Dosage : _____

Frequency: _____

Reason for Taking: _____

_____

MEDICATION

Dosage : _____

Frequency: _____

Reason for Taking: _____

_____

PARENT'S AUTHORIZATION FOR MEDICAL TREATMENT

The information on this form is correct and complete so far as I know, and the person herein described has permission to engage in all prescribed Summer Camp @ Phoebe Needles activities, except as noted by me.

I understand that there is a certain degree of risk and possible injury by reason of the program and its activities. I hereby give my permission to the staff of the Phoebe Needles Center, Inc. to provide routine health care, administer prescribed medications and seek emergency medical treatment, including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give my permission to the Phoebe Needles Center, Inc. to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give my permission to the physician selected by the Phoebe Needles Center, Inc. to secure and administer treatment, including hospitalization, for the above named person. This completed form may be photocopied for trips off the Phoebe Needles Center, Inc. property.

Parent/Guardian Signature _____

Print Name _____

Relationship _____

Date _____

USE OF OVER-THE-COUNTER MEDICATIONS

Circle "yes" or "no" to any over-the-counter medications your camper may or may not receive if needed while at camp at the Phoebe Needles Center.

Acetaminophen or Tylenol (pain)	Yes	No
Pepto Bismol or generic (upset stomach)	Yes	No
Cough Suppressant plain (cough)	Yes	No
Benedryl pills or generic (itching or rash)	Yes	No
Ibuprofen or Advil (inflammation)	Yes	No
Cough drops/throat lozenges	Yes	No
Effervescent Pain Reliever	Yes	No
Antacid Tablets	Yes	No
Anti-diarrheal (diarrhea)	Yes	No
Calamine Lotion or Cortaid (itching or rash)	Yes	No
Hydrocortisone 1% Cream (itching)	Yes	No

PLEASE RETURN ALL MATERIALS TO:

The Phoebe Needles Center, Inc.
732 Turners Creek Road
Callaway, Virginia 24067-5814
(540) 483-1518 (800) 848-1677
Fax (540) 483-2235 Email PNCenter@gmail.com
Additional forms available at www.PhoebeNeedles.org