PHOEBE NEEDLES CENTER, INC.

DAY CAMP MEDICAL INFORMATION FORM

Camper's Name _____
(First) (Middle) (Last) (Preferred)

Date of Birth JAN 1 2009 _____ Gender _____

Parent/Guardian's Name _____

Street Address _____

City, State, Zip Code _____

Primary Phone Number _____ Secondary Phone Number _____

In Case of Emergency, contact _____ Relationship _____

Primary Emergency Phone _____ Secondary Emergency Phone _____

What is the current status of your youth's health? Good ☐ Fair* ☐ Poor* ☐

* Explain _____

Name of your physician or clinic _____ Clinic/Doctor Phone Number _____

Does the child attending camp have health insurance coverage? Yes ☐ No ☐

Name of Insurance Company _____ Policy/Group Number _____

Identification Number _____ Insurance Co. Phone Number _____

Insurance Co. Address _____

Is your youth allergic to BEE or WASP stings? Yes ☐ No ☐ If YES, will they have medication? Yes ☐ No ☐

List any ACTIVITIES from which your youth should be restricted _____

List any dietary restrictions that apply to your youth _____

FOR OFFICE USE ONLY (to be completed by medical screener, screener should initial)

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

CAMPER'S NAME _____

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 if none, state "NONE":

MEDICATIONS: _____

_____

Reactions: _____

Treatment: _____

FOODS: _____

_____

Reactions: _____

Treatment: _____

PLANTS, ANIMALS, ETC.: _____

_____

Reactions: _____

Treatment: _____

OTHER: _____

_____

Reactions: _____

Treatment: _____

☐ Check this box to give PNCI staff permission to apply **SUNSCREEN** to your camper if they need assistance.

Is there any other information you think we should know about your camper? _____

_____

VERIFICATION OF IMMUNIZATIONS

I, _____ (custodial parent/legal guardian), attest that, _____ (camper), has received **ALL** immunizations required for public schools in Virginia, and that these immunizations are up to date as of June 1, 2023: Diphtheria, Tetanus, & Pertussis (DTaP, DTP, or Tdap); Haemophilus Influenzae Type b (Hib) Vaccine; Hepatitis B Vaccine; Human Papilloma-virus Vaccine (HPV); Measles, Mumps, & Rubella (MMR) Vaccine; Pneumococcal (PCV) Vaccine; Polio Vaccine; Varicella (Chickenpox) Vaccine

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

CAMPER'S NAME _____

MEDICATIONS

All medications (prescription and non-prescription) must be brought to camp IN THE ORIGINAL CONTAINER OR PACKAGING, which must include prescribing 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."

NAME OF MEDICATION _____

Dosage: _____

Frequency: _____

Reason for Taking: _____

_____

NAME OF MEDICATION _____

Dosage: _____

Frequency: _____

Reason for Taking: _____

_____

NAME OF MEDICATION _____

Dosage: _____

Frequency: _____

Reason for Taking: _____

_____

NAME OF 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 in regard to the nature of 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 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 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 Phoebe Needles Center, Inc. property.

During the time your youth is attending camp at Phoebe Needles Center, Inc., they will be provided with secondary insurance coverage for medical expenses due to accident or illness. This includes activities on and off 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 Phoebe Needles Center, Inc.

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
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:

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