PHOEBE NEEDLES CENTER, INC.

DAY CAMP MEDICAL INFORMATION FORM

Camper's Name ____

(First) (Middle) (Last) (Preferred)

Date of Birth ______________________ 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 ______________________

____

<u>FOR OFFICE USE ONLY</u> (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:

Question		
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. 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, ________________________ , attest that, ____________________________, has received
(custodial parent/legal guardian) (camper)

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 Papillomavirus 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 week 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 the program and its activities. I hereby give my permission to the staff of 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

Indicate "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.

Medication		
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