District 5110 Camper Health Information

CAMPER NAME: _____ Sex : M ☐ F ☐ *Gender Identity* *M* ☐ *F* ☐

Name of FAMILY PHYSICIAN_____ Phone_____

Name of DENTIST/ ORTHODONTIST_____ Phone_____

MEDICAL/HOSPITAL INSURANCE CARRIER_____

GROUP OR POLICY NUMBER_____

Name of insured_____ Relationship to camper_____

NOTE: In order to facilitate treatment in an emergency, please attach a photocopy of your health insurance card (front and back).

HEALTH HISTORY: Provide approximate dates.

Frequent Ear Infections_____ Hay Fever_____ Insect Stings _____

Heart Defect/Disease_____ Diabetes_____ Poison Oak _____

Convulsions_____ Other_____

Bleeding/Clotting Disorder _____ Asthma _____

Chronic Conditions/Allergies***** _____

Operations or serious injuries (provide dates and details) _____

_____

Date of most recent tetanus shot _____ ***(A Current Tetanus Shot Is Highly Recommended.)***

Chronic or recurring illnesses_____

Physical limitations Camp RYLA staff should be aware of_____

Please explain all dietary issues and/or special food needs of which Camp RYLA staff should be aware of: _____

_____

***Camp RYLA cannot accommodate campers diagnosed with severe nut allergies**

My/Our son/daughter regularly takes the following medications and will have them in his/her possession at Camp:
(Please describe fully, add a separate page, if needed and, if "none," please so state.)

Name of Medication: _____

Special instructions/Reason for Medication _____

Dosage_____ Frequency_____

Name of Medication: _____

Special instructions/Reason for Medication _____

Dosage_____Frequency_____

Other recommendations, restrictions, or important information_____

Permission to Provide Necessary Treatment or Emergency Care: I/We hereby give permission to the medical personnel selected by the Camp Director to order x-rays, routine tests, treatment, to release any records necessary for insurance purposes, and to provide or arrange necessary related transportation for me or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Director to secure and administer treatment, including hospitalization, for the person named above. I assume responsibility for any medical or treatments fees or costs incurred directly or indirectly because of said minor's participation. This completed form may be photocopied for trips out of camp.

Date: _____ _____ Parent/Guardian Signature _____ Parent/Guardian Signature

Please complete this form, save as a PDF document and return it to Camp Director PDG Dell Gray at the email listed here.

PDG Dell Gray
168 Snowberry Road
Roseburg, OR 97471

Email: dggray5110@gmail.com
Mobile: 541-580-0401