Camp Calvin 2022

Health History and Medical Authorization Form

Child's Name: ____________________ Date of Birth:__________ Age:__________

Address:____________________ City:__________ State:______ Zip:______

Church:______________________________

PARENT/GUARDIAN INFORMATION

Parent/Guardian 1: ______________ Address (if different than child's):______________

Phone #1: ______________ Phone #2:______________ Email: ______________

Parent/Guardian 2: ______________ Address (if different than child's):______________

Phone #1: ______________ Phone #2:______________ Email: ______________

EMERGENCY CONTACT INFORMATION

Name:__________ Relationship:__________ Phone #1:__________ Phone #2:__________

Name:__________ Relationship:__________ Phone #1:__________ Phone #2:__________

HEALTH INFORMATION

Health Conditions: ______________________________

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Explain any specific needs or accommodations required: ______________________________

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Explain any known behavioral and/or emotional problems: ______________________________

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Explain any operations or serious injuries: ______________________________

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Explain any disabilities or chronic or recurring illnesses: ______________________________

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Explain any activities that are discouraged or limited by you or your child's physician: ______________

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Explain any dietary modifications: ______________________________

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IMMUNIZATION HISTORY

Are all immunizations current? ☐ Yes ☐ No Date of last DTP or DT (Tetanus): ____________________

Please submit proof of COVID-19 vaccination with your child's camp application.

Camp Calvin is in compliance with Washington State regulations for overnight camping (https://www.governor.wa.gov/issues/issues/covid-19-resources/covid-19-reopening-guidance). We will continue to monitor the changing regulations and adapt our policies accordingly.

All campers must be fully vaccinated before coming to camp. An individual is considered fully vaccinated for COVID-19 two weeks after they have received a second dose in a 2-dose series (Pfizer-BioNTech or Moderna), or at least two weeks after they received a single-dose vaccine (Johnson and Johnson (J&J)/Jannsen). Verification of vaccination or test results is required. Documentation of COIVD-19 vaccination must be an official record.

If the camper is not vaccinated, they must quarantine for 72 hours prior to arrival at camp and receive a negative COIVD-19 test no more than 72 hours prior to arrival at camp. Any unvaccinated individual attending camp may **also** be asked to take a rapid antigen test upon arrival to camp.

Under state Safety and Health requirements of Washington state, anyone unable to meet one of these two conditions is not allowed to participate in camp.

MEDICATION INFORMATION

Are any prescription medications being taken? ☐ Yes ☐ No Are any of the following used? ☐ Inhaler ☐ EpiPen

Name of Medication	Reason for Medication	Dose	Frequency

You may send medications with your child for your child to self-administer at camp. If you want the camp nurse to administer any medication, please send the medication with a prescription/doctor's order, including the child's name, medication name, dose, route, and time to be administered. The nurse may not legally administer any medication without a doctor's order.

AUTHORIZATION FOR HEALTH CARE

This health history is correct so far as I know. The person herein described has permission to engage in all activities except as noted. I hereby give permission to the Camp Nurse or First-Aider to provide routine health care and witness prescribed medications. I consent for my child to receive such medical treatment and/or surgical procedures as are deemed necessary in the event of an emergency. Should a medical emergency arise during my child's participation in a Camp Calvin activity, I understand that reasonable efforts will be made to contact me or my designated alternate at the phone numbers I have given. If it is believed my child's life or health may be adversely affected by the delay that an attempt to contact me or my designated alternate would cause, I consent to the administration of medical treatment and/or surgical procedure deemed necessary by the medical doctor and/or medical facility and the immediate administration of life-sustaining measures deemed necessary under the circumstances. This completed form may be photocopied.

Parent/Guardian Signature:____Date: ____________________________________