

Allergies: Check those which apply to this camper.

- This camper has **no known allergies**
- This camper is allergic to the following medication: _____ Describe reaction: _____
- This camper is allergic to the following food(s): _____ Describe reaction: _____
- This camper is allergic to the following: _____ Describe reaction: _____

Medications: Please list **ALL** medications (including over the counter or nonprescription medications) taken routinely. Bring enough medication to last the entire time at camp. Medications must be in the original packaging/bottle that identifies the prescribing physician (if a prescription drug) the name of the medication, dosage, and the frequency of administration.

- This person takes **NO** medications on a regular basis.
- This person takes medications listed below, including over the counter medications:

| | |
|---|--|
| Name of medication: _____ | Name of medication: _____ |
| Reason for taking: _____ | Reason for taking: _____ |
| Dosage: _____ | Dosage: _____ |
| Specific times taken each day: _____ | Specific times taken each day: _____ |
| Date medication started: _____ | Date medication started: _____ |
| Most recent change in dosage (if any) _____ | Most recent change in dosage (if any): _____ |

Chronic Concerns: Check all that pertain to this individual, and provide information about supportive healthcare

- This individual has no chronic health concerns and is capable of full participation in camp program
- This individual has the following chronic health concerns:
 - Asthma
 - Headaches
 - Sleepwalking
 - Frequent ear infections
 - Diabetes
 - Bedwetting
 - Menstrual cramps
 - Frequent colds
 - Seizures
 - Other (please describe) _____

Provide information about supportive health care for each checked item: _____

Mental and Emotional Health: If this individual receives care or takes medication for emotional, learning and/or

psychological concerns, provide background information to help us work effectively with this camper or adult: _____

Immunization History: Enter the date each immunization was given.

| Immunization | | | | |
|--|--|--|---|--|
| <i>DPT: Diphtheria, Tetanus, Pertussis</i> | | | | |
| <i>Td/DT: Tetanus Diphtheria</i> | | | Must be current within past 10 years | |
| <i>MMR: Mumps, Measles, Rubella</i> | | | Measles booster (prior to 7th grade) | |
| <i>IVP/OPV: Polio</i> | | | | |
| <i>HepB: Hepatitis B</i> | | | | |
| <i>Hib: H, influenzae, type b</i> | | | | |
| <i>Varicella: Chickenpox</i> | | | History of disease. Yes _____ Year _____ (optional) | |

Health Center Medications: These medications are stocked by Sonlight, used to help manage common illness or injury. They are administered as directed by our medical protocols. Cross out those which your camper should not be given.

- | | | | |
|--|-------------------------------------|-----------------------------|---------------------|
| Acetaminophen (<i>Tylenol</i>) | Diphenhydramine (<i>Benadryl</i>) | Ibuprophen (<i>Advil</i>) | Nix |
| Double Antibiotic Cream | Kaopectate | Aloe Vera | Chamomile Tea |
| Night Time Cold Formula | Lidocaine 2% Topical | Calamine Lotion | Generic cough drops |
| Chlorpheniramine (<i>Chlor-Trimeton</i>) | Hydrocortisone Cream | Opcon-A eye drops | Claritin |
| Guaifenesin DM (<i>Robitussin</i>) | Pseudoephedrine (<i>Sudafed</i>) | Tums antacid | |

Billing Information for Health Care:

Participants in **Sonlight Summer Camps** (programs sponsored by Sonlight) are covered by limited accident/sickness insurance provided by Sonlight. (Not a major medical policy). Campers and adults attending Sonlight with a church or organization (i.e. rental groups) should check with their leader for details regarding accident/sickness insurance, if any, their organization provides. (Some provide no insurance).

Is this participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name: _____

Name of insured: _____ Relationship to insured: _____

Social security number of policy holder or insurance ID number: _____

Authorization for Health Care:

The health history is correct, and the person described has permission to participate in all camp activities except as noted by me and/or the examining physician. I have received and read the letter from the camp director regarding activities my child/myself might participate in. I give permission for Sonlight staff to administer first aid and/or transport as they see needed and to turn care and transport over to ambulance or search and rescue personal if the need should arise. I give permission to the physician selected by Sonlight to order X-rays, routine tests and treatment for the health of me/my child. If I cannot be reached in an emergency, I give permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for me/my child. Sonlight has permission to obtain a copy of my/my child's health record from the providers they access to treat my child. I understand that information about me/my child's health will be shared on a "need to know" basis with other Sonlight Camp staff, to include food service staff, and/or counseling staff. I understand that Sonlight is in a rural environment. Treatment for me/my child by a physician may be hours from Sonlight resident camp, and much longer for excursions or outcamps. The nearest hospital to Sonlight resident camp is 75 miles away. This form may be photocopied.

Signature of Parent/Guardian or Adult Participant: _____ Date: _____

Authorization for Rafting: (*For Sonlight camps only. Not all groups that use Sonlight offer rafting*)

I hereby grant permission for my child to participate in whitewater rafting facilitated by Sonlight Adventures, Inc., and contracted to a rafting company. I understand that my child will be traveling by bus to an offsite location for rafting.

Signature of Parent/Guardian or Adult Participant: _____

Sonlight Nursing Notes

_____ **Entrance Screening** conducted according to Sonlight protocols, and significant findings noted.

| | | | |
|------------------|--|-----------------------------|---|
| <i>Date/Time</i> | A. Signs/symptoms of illness/injury upon arrival?..... | <input type="checkbox"/> No | <input type="checkbox"/> Yes as noted below |
| _____ | B. History of exposure to communicable disease?..... | <input type="checkbox"/> No | <input type="checkbox"/> Yes as noted below |
| <i>Screener</i> | C. Additions or corrections to this health history?..... | <input type="checkbox"/> No | <input type="checkbox"/> Yes as noted below |
| <i>Initials</i> | | | |

Medications given to healthcare provider: _____

This child may **not** leave camp with the following individual(s): _____

Exit Note Check one of the following:

- Left camp this day with no reported illness/injury
 - Left camp this day with the following problem/concern _____
- This problem was referred to (*name of responsible party*) _____

Date: _____

Initial: _____

Health Care Recommendations from a Licensed Physician or Nurse Practitioner:

To Physicians and Nurse Practitioners: This individual has enrolled in a summer camp program at Sonlight Camp, in southwest Colorado. The program is based at 8,000 feet above sea level. The program involves physical activity (climbing wall, mountain biking, archery, white water rafting, hiking). Our healthcare staff will use your information to meet the health needs of the person described. Note that not all healthcare staff are registered nurses; some have only first aid skills. For further clarification of the camp program and activities, please feel free to call: 970.264.4379 or visit our website: www.sonlightcamp.org.

To be completed by a physician or nurse practitioner based on an examination done within 2 years of camp participation.

Date of examination _____ BP _____ Weight _____ Height _____

This individual is under the care of a physician for the following: _____

Recommendations and Restrictions:

Physician order for medication (prescription and over the counter) and/or treatment to be administered at camp:

Description of prescribed meal plan or dietary restrictions:

Known allergies:

List activities in which this person should not participate, or have limited participation (describe limitation):

Additional information for health care staff at camp, to include significant medical history:

General History:

Circle the appropriate response for each statement

YES NO This individual has had mononucleosis in the past 12 months

YES NO This individual has a history of illness, injury or surgery which will affect participation.

If "yes" explain:

Signature of Physician or Nurse Practitioner: _____
Printed Name: _____
Address _____
Phone: (_____) _____ Date: _____