# <u>Confidential Medical Form</u>
# Joy Outdoor Education Center
# Camp WEKANDU

## INTRODUCTION

**The attached information forms should be completed and delivered or mailed to the following address by May 28, 2012.**

**Cincinnati Children's Hospital Medical Center**
**ATTN: Daniel Lovell**
**Division of Rheumatology, ML4010**
**3333 Burnet Avenue**
**Cincinnati, OH 45229-3039**

If the camper is on any medication prescribed by a physician, please remember to **PACK AN EIGHT-DAY SUPPLY.** Each prescription medication must be in the pharmacy container, properly labeled including the camper's name, medication name, and dose. All over-the-counter medications must be in the manufacturer's container with the name of the camper written on the container. Scheduled medications are dispensed at breakfast, lunch, dinner, and bedtime. The Camp Nurse will begin dispensing scheduled medications starting at bedtime the first camp day. Please make sure any medications due before that time are given before registration.

On the last day of camp (Friday) the Camp Nurse will dispense medications at breakfast and lunch. As part of the check-out process you will be given your child's medications so that you can give the dinner time medications if there are any. Dinner on the last day is provided by the camp for families as part of the closing ceremonies.

**Medications should be kept separate from the suitcase and given to the camp nurse upon arrival at camp. NO prescribed or over-the-counter medications, including alternative medications and nutritional supplements, are permitted in the camper's possession without permission of the physician in attendance.** All camper's medicines, vitamins, etc., will be kept by the nurse and dispensed according to your physician's written instructions

If the camper is currently using splints, crutches, walker, wheelchair, or scooter - these items **must** be brought to camp.

No child who has been exposed to a communicable disease (measles, mumps, chicken pox, etc.) should be sent to camp before the period of incubation has elapsed. If there is any question about this, please consult your physician.

We assure you that excellent medical care will be provided during camp. A pediatrician, nurse, physical or occupational therapist, or social worker will be at the camp 24 hours per day and other staff of the CCHMC Rheumatology Team will visit daily. Should a child develop a special medical problem while at camp, the parents will be notified by telephone.

## GENERAL INFORMATION

Camper's Name: ___ _____ _____ _____
Last First Middle

Birth Date: _____/_____/_____ Sex: M [ ] F [ ] Age at Start of Camp_____

Parent/Guardian Name: _____

Home Address: _____City: _____ State: _____ Zip: _____

Daytime phone: (_____) _____-_____ Evening phone: (_____) _____-_____

## EMERGENCY CONTACTS
**(Must be completed)**

**If Parent/Guardian is not available in case of an emergency please notify.**

**FIRST CONTACT:**

_____
Name Relationship

_____
Address City State

Phone: **(_____) _____-_____** Alternate Phone: **(_____) _____-_____**

**SECOND CONTACT:**

_____
Name Relationship

_____
Address City State

Phone: **(_____) _____-_____** Alternate Phone: **(_____) _____-_____**

**NAMES OF PERSONS OTHER THAN PARENTS TO WHOM CHILD MAY BE RELEASED:**

1. Name _____Relationship _____
2. Name _____Relationship _____
3. Name _____Relationship _____

## INSURANCE INFORMATION

**Primary Insurance Company:** _____Policy Number: _____

Effective Date: ____/____/____ Name of person carrying insurance: _____

**Secondary Insurance Company:** _____ Policy Number: _____

Effective Date: ____/____/____ Name of person carrying insurance: _____

**Medicaid or other third-party payer:** _____Case Number: _____

## GENERAL HEALTH HISTORY

### ALLERGIES

| | YES | NO |
|---|---|---|
| Asthma | ___ | ___ |
| Hay Fever | ___ | ___ |
| Poison Oak/Ivy | ___ | ___ |
| Insect stings | ___ | ___ |
| Foods | ___ | ___ |
| Penicillin | ___ | ___ |
| Aspirin | ___ | ___ |
| Other Drugs: | ___ | ___ |

_____
_____
_____
_____

### MEDICAL PROBLEMS

| | YES | NO | DATES |
|---|---|---|---|
| Ear Infections | ___ | ___ | _____ |
| Seizures | ___ | ___ | _____ |
| Sleepwalking | ___ | ___ | _____ |
| Bedwetting | ___ | ___ | _____ |
| Fears/Phobias | ___ | ___ | _____ |
| Hyperactivity | ___ | ___ | _____ |
| *Head Lice | ___ | ___ | _____ |
| Behavior Disorder | ___ | ___ | _____ |
| Chicken Pox | ___ | ___ | _____ |
| Measles | ___ | ___ | _____ |
| German Measles | ___ | ___ | _____ |
| Mumps | ___ | ___ | _____ |
| Bleeding disorder | ___ | ___ | _____ |
| Blood clots | ___ | ___ | _____ |
| Hepatitis A | ___ | ___ | _____ |
| Hepatitis B | ___ | ___ | _____ |
| Separation Anxiety | ___ | ___ | _____ |

**** All children will be checked for head lice at registration. Anyone with head lice will be treated appropriately at that time.***

Indicate Operations/Serious Injuries and Dates:

1._____ Date: _____

2._____ Date: _____

Additional Suggestions/Information from Parent about general health:

_____

_____

_____

**IMMUNIZATION HISTORY:**

| | YES | NO |
|---|---|---|
| Are school immunizations up to date? | _____ | _____ |
| Has child received the varicella (chicken pox) vaccination? | _____ | _____ |

**PERTINENT TO FEMALE CAMPERS ONLY:**

| | | |
|---|---|---|
| Has this person menstruated? | _____ | _____ |
| If not, has she been told about menstruation? | _____ | _____ |
| If so, are her periods normal? | _____ | _____ |

**ADDITIONAL SPECIAL CONSIDERATIONS/INSTRUCTIONS:** _____
_____

## RHEUMATIC DISEASE HISTORY

Name of child's rheumatic disease: _____

Name of child's Rheumatologist: _____

Current problems and symptoms of rheumatic disease:
_____

_____

_____

How long has your child had Rheumatic disease?_____

Does child have a physical and/or occupational therapy exercise program? YES_____ NO_____

**If yes, please include a copy of the exercises that were prescribed. If you do not have a copy, describe these exercises and the frequency they should be performed on the reverse side of this sheet.**

Does the camper wear/use splints or any other appliances?
YES_____ DAY_____ NIGHT_____
NO_____

What appliance/splint? _____ When? _____

**SPECIAL DIET**

Does your child have any special diet or food allergies/intolerances that will need attention while at Camp Wekandu?
YES_____
NO_____

If YES, please describe specifically:
_____
_____

## MEDICATIONS

**(If medications are to be taken while at camp, please include instructions)**

| Medication Name/Strength | DOSE (How many or How much) | WHEN (Breakfast, Lunch, Dinner, Bedtime) |
|---|---|---|
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**(use reverse side of this sheet if you need more room for listing medications)**
**See reverse side_____**

**Can Camper have the following medications, if needed? (See #5 in Waiver section, where parent signature is required)**

**Acetaminophen (Tylenol) YES____ NO____**
**Antihistamine (Benadryl) YES____ NO____**

**NOTE: If any medication changes occur between the time of submission of this form and the start of camp, a written notification must be provided to the Camp by the child's physician.**

## GUIDELINES REGARDING CAMPER ACTIVITIES

The Camp counselors need guidelines regarding what kinds of activities each individual camper may be allowed to participate in, and which activities should be discouraged or prohibited. Please indicate whether you think your child should be permitted to participate in the various activities listed.

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**UNRESTRICTED** means your child should be allowed to participate fully in any given activity.

**PERMITTED WITH CAUTION** means that your child should be permitted to do an activity, but should be watched to make sure he/she is careful and does not overdo.
**NOT PERMITTED** means the child cannot participate in the particular activity.

For each listed activity, please indicate with a check mark, whether your child's participation should be **UNRESTRICTED, PERMITTED WITH CAUTION,** or **NOT PERMITTED.** Please check only one possibility for each activity!

Please indicate whether the various walking activities should be undertaken with ambulatory aids (wheelchair, scooter, wagon, crutches, cane, walker, or walking stick).

| | UNRESTRICTED | PERMITTED WITH CAUTION | NOT PERMITTED |
|---|---|---|---|
| ▪ Long walks | _____ | _____ | _____ |
| ▪ Short walks | _____ | _____ | _____ |
| ▪ Walking to usual activities | _____ | _____ | _____ |
| ▪ Swimming | _____ | _____ | _____ |
| ▪ Fishing | _____ | _____ | _____ |
| ▪ Horseback riding | _____ | _____ | _____ |
| ▪ Row boating/canoeing | _____ | _____ | _____ |
| ▪ Archery | _____ | _____ | _____ |
| ▪ Wall climbing | _____ | _____ | _____ |
| ▪ Non-competitive ball games | _____ | _____ | _____ |

Are there any special activities or areas you desire the camp staff to evaluate and/or work on during camp?

_____

## APPROVAL OF PEDIATRICIAN OR RHEUMATOLOGIST

_____ is able to attend camp and participate in activities with the restrictions and recommendations as indicated under "Guidelines Regarding Camper Activities". I have reviewed the general medical history, the rheumatologic history and medication list. All data on this sheet is accurate at this time.

ADDITIONAL COMMENTS: _____

_____

Physician's signature: _____ Date: _____

Physician's printed name: _____

Physician's phone number: _____

## RELEASE AND PERMISSION FORMS

### 1) JOY OUTDOOR EDUCATION CENTER ACKNOWLEDGEMENT OF RISK & RELEASE

In consideration of the acceptance of _____

Camper's name

- I understand that my participation in programs offered by Joy Outdoor Educational Center is based on a "Challenge by Choice" philosophy. I recognize that the program is designed to use experiential, engaging, teaching techniques, but that my participation is purely voluntary, and I elect to participate in spite of the risks.
- I am aware that experiential, outdoor pursuits such as living history reenactments, climbing, hiking, high ropes courses, ground initiatives, and other activities at Joy Outdoor Education Center, for which I and/or my child have enrolled, entails certain risks.
- I understand that completing and signing the Center's Confidential Medical Information Form is a prerequisite to participate in this program. The information my child or I have provided is a complete and accurate statement of the physical and psychological factors, which may affect participation in the program.
- Therefore, for myself/my child, I expressly, knowingly, and voluntarily assume all risks involving my participation, and do hereby release Joy Outdoor Education Center and its members, trustees, officers, employees, independent contractors and agents from any and all liability, damages, costs and expenses arising out of or related to bodily or psychological injury, loss of life or personal property that may occur as a result of participating in this program.
- I have read and understand and accept the terms and conditions stated herein or have had them read and explained to me and accept these terms and conditions and acknowledge that this agreement shall be effective and binding upon the parties during the entire period of participation in the said program.
- The health history provided in the Confidential Medical Form is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted therein.

**AUTHORIZATION OF TREATMENT:**

I hereby give permission to the medical personnel selected by the visiting organization to arrange necessary related transportation for this participant and assist with prescription and over-the counter medication if needed. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the visiting organization of Camp Joy to secure and administer treatment, including hospitalization, for the person named above.

Signature of participant _____Date _____

Parent/s signature _____Date _____

**(REQUIRED) if person is under 18 yrs of age**

**NOTE: Upon admission for emergency treatment, parent or legal guardian assumes complete responsibility for payment of the cost of said treatment.**

Parent/Guardian Signature _____Date _____

**2) PHOTO RELEASE**

I agree to allow images of my child to be used by Joy Outdoor Education Center, Cincinnati Children's Hospital Medical Center, and the Special Treatment Center for Juvenile Arthritis for publicity or educational purposes including leaflets, flyers, television, newspaper, magazines or advertisement. Images may be released without identifying information to donor agencies.

Parent/Guardian Signature _____Date _____

**3) TRAVEL PERMISSION**

I agree to allow above named camper to participate in field trips and to permit travel involved as normal part of Camp Joy/Wekandu at Camp Joy, Cincinnati Children's Hospital Medical Center or the Special Treatment Center for Juvenile Arthritis. This will include transportation service provided by Camp Joy to and from any programs, sessions, or periods.

Parent/Guardian Signature _____Date _____

**4) WHEELCHAIR REPAIR**

My child will be bringing his/her wheelchair to camp YES_____NO_____

Type of chair_____

I release Camp Joy/Wekandu and the Special Treatment Center for Juvenile Arthritis, Cincinnati Children's Hospital Medical Center from responsibility should my child/s chair require repair during camp.

- If the chair needs repair, I wish the camp staff to proceed with having repairs made ___yes ____no

- I will assume financial responsibility for these repairs.

Parent/Guardian Signature _____Date _____

**5) MEDICATIONS**

I give Camp Joy /Wekandu permission to:

1. Dispense Acetaminophen (Tylenol) to camper.
   YES____ NO____

2. Dispense Antihistamine (Benadryl) for bug bites or rashes
   YES_____ NO_____

I hereby give permission (standing orders) to Camp Joy/Camp Wekandu medical personnel to dispense medications brought to Camp by parent or guardian, or prescribed by the Camp's physician while in attendance.

Parent/Guardian Signature _____ Date _____

**CAMP WEKANDU PERSONAL INFORMATION FORM**

***(To be completed by parent or guardian)***

**In order for the counselors to work more effectively with each camper**, the following information is needed before the camp sessions begin.

Camper's name _____

Grade next school year _____ School _____

Nickname _____

This is my child's _____ year at Camp Wekandu

Does your camper have any fears? _____

_____

Please indicate what you hope your camper will gain from this Camp experience? _____

_____

_____

State any special needs your camper may have. _____

_____

_____

Revised 4-14-2012 dl/tm