

Camper Screening

Week # _____



Camper's Name _____

Cabin _____ Counselor's Name _____

(Please explain "YES" responses on the back of this form.)

YES/NO Have you been sick within the last 14 days?

YES/NO Does the camper feel like s/he is running a fever?

YES/NO Has the camper been exposed to a contagious illness in the last 14 days?

YES/NO Does the camper have any visible signs of injury (cuts, bruises, etc.) or any rashes or itches?

YES/NO Has the camper had any change in their health or immunization status since the Health History information was completed?

YES/NO Does the camper have any over-the-counter or prescription medications in his/her luggage? (take home or give to nurse)

YES/NO Does the camper have a cell phone in their possession or luggage? (not allowed—parents please take home)

YES/NO Is the camper allergic to foods, medicines, or bee stings? (If yes, please list reactions and severity on back of this page)

YES/NO Does the camper have any physical restrictions to what s/he can do at camp? (If yes, please list on back of this page)

2011 Check-in Form

Camper Name

Camper Medication Record

Custodial Parent/Guardian _____ Phone _____

Second Parent/Guardian _____ Phone _____

Name of family physician _____ Phone _____

Parents Complete <i>Please list only the medications to be taken at camp</i>	Nurse Completes													
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DO NOT WRITE HERE																	
	FOR OFFICE USE ONLY																
	Date		Sun		Monday		Tuesday		Wednesday		Thursday		Friday				
Time	D	H	B	L	D	H	B	L	D	H	B	L	D	H	B	L	D
Name of medication _____ Amount of each dose _____																	
Circle all times to be given: Breakfast – Lunch – Dinner – Bedtime																	
Name of medication _____ Amount of each dose _____																	
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Circle all times to be given: Breakfast – Lunch – Dinner – Bedtime																	

Medication Administration Signature/Initial _____

Health Information Release, Permission to Treat, Transport and Use Likeness

- I attest that the health history information I completed online during the registration process for the above-named camper is current, correct and accurately reflects the health status of said camper. This camper has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.
- I attest that the information given in the above "Camper Screening Form" and "Camper Medication Record" is accurate and truthful.
- I understand that all medications for my Outpost Camper (if enrolled in the Outpost Program) will be administered by the Outpost Director, Assistant Director or Trip Leader and that the camp nurse will serve Outpost in a consultative or emergency role only.
- I give permission to the camp staff to transport my camper for emergency or programmatic purposes at the discretion of the director.
- For good and valuable consideration, we hereby consent to and authorize the reproduction, publication, and use by Camp Glisson and their successors and assigns, for advertising, commercial, or any other purpose, of any photograph, picture video or likeness of my child or other family members.

Signature of Parent or Legal Guardian _____ Date _____