

HEALTH CERTIFICATE for CAMP HOPE

• [] Camper [] Staff •

Participants Name _____ []M []F Birth date _____ Age _____ Grade _____

Parent/Guardian Name _____ Relation to camper _____

Address _____ City _____ State _____ Zip _____

Home phone # _____ Cell phone# _____ Email: _____

Place of Employment _____ Work Phone# _____

Doctor _____ Phone# _____ Dentist _____ Phone# _____

Medical Insurance Co. _____ # _____ Phone () _____

Address _____ City _____ State _____ Zip _____

^Y ^N Drug or Allergic reactions? _____

Is Tetanus shot current? Please list date: _____

Any serious illness, operation or injuries? _____

Is treatment continuing? _____

Any disabilities or limitations on activities? _____

Any necessary special diet? _____

STATE REGULATION: All prescriptions*, over the counter medications and supplements MUST be in the original labeled container AND accompanied by a doctors note or we can not administer them to the camper! *From a licensed pharmacy, labeled properly, including the campers name, directions for use and name of the prescribing practitioner.

Please list all prescriptions, over the counter medications and supplements camper will be taking at camp, include directions for use and possible side effects: (Be sure you have a Doctor's note for all!) _____

Parents or Guardians,

I hereby give my permission for my child to take the medications and supplements listed above, at camp, as ordered. I understand it is my responsibility to provide them in compliance with state regulations. I understand that camp uses a Physician Approved Medication list as needed. (Including but not limited to, ibuprofen, acetaminophen, antacids, allergy relief, triple antibiotic cream and more.)

● **Signature** _____ **Date** _____

IMMUNIZATIONS: Colorado State Law requires that each participant includes a copy of their immunization

Doctor: I have examined this camper and find him/her to be in satisfactory physical condition, free from any contagious disease and capable of active participation in the regular camping program except as stated above.

● **Examining Doctor's Signature** *Signature REQUIRED!!* **Date** _____

IN CASE of an EMERGENCY

If I/we cannot be reached you may contact:

Name _____ Relation _____ Phone _____

Address _____ City _____ State _____ Zip _____

In an Emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the physician selected by the Camp Director to hospitalize and secure proper treatment (including surgery) for my child.

● **Signature** *Signature REQUIRED!!* **Date** _____

● **NOTE:** This form must be filled out completely with signatures for us to accept your child as a camper!