



Sierra Mountain Music Camp Summer 2012

STATEMENT OF MEDICAL HISTORY, AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT AND RELEASE OF LIABILITY

This form must be ***FILLED IN AND SIGNED*** by parent(s) or guardian(s) and returned immediately. **No one will be allowed to remain at camp without this completed, signed form on file.** Please provide a **copy** of the insured's benefit card if possible. Please provide **small photo** for identification purposes (school picture ok) if possible.

The following section MUST be filled out completely			
Camper's Name		Home Phone #	
Street Address			Birthdate ___/___/___
City	State	Zip	Age (at camp)
Camper's Description			
Male <input type="checkbox"/> Female <input type="checkbox"/>	Height	Weight	Hair Color
			Length
			Eye Color
			Glasses? <input type="checkbox"/>
Custodial Parent			NEW CAMPER OR ALUMNI? <small>(circle one)</small>
Mother's Name	Cell #	Work #	
Father's Name	Cell #	Work #	
If parents cannot be reached in an emergency, please list two contacts:			
Name	Day#	Evening#	Cell#
Name	Day#	Evening#	Cell#
Camper's Physician's Name		Phone#	
Health Insurance Co.		Policy#	
Subscriber Name		Subscriber ID#	
Date of camper's last physical?		Group#	
Swimmer? Yes <input type="checkbox"/> No <input type="checkbox"/> Ability Level?		Blood Type (if known):	

Please check all medical, emotional, mental or other health factors or conditions which *recently or currently* applies to your camper, including, but not limited to (explain causes below, use another sheet if necessary)

- | | | |
|---|--|---|
| <input type="checkbox"/> Asthma or breathing difficulty
<input type="checkbox"/> Heart conditions or surgeries
<input type="checkbox"/> Recent sprains or broken bones
<input type="checkbox"/> Hemophilia or bleeding disorders
<input type="checkbox"/> Heart murmurs
<input type="checkbox"/> Chronic or recurring illness
<input type="checkbox"/> Kidney/liver disease
<input type="checkbox"/> History of diarrhea or constipation
<input type="checkbox"/> Immunodeficiency disorders (HIV/AIDS)
<input type="checkbox"/> Mouth sores, canker sores or herpes
<input type="checkbox"/> Extreme homesickness or shyness
<input type="checkbox"/> Fatigue or mononucleosis (12 mos.)
<input type="checkbox"/> Fears/phobias
<input type="checkbox"/> ADD or ADHD
<input type="checkbox"/> sleep disorders or bedwetting
<input type="checkbox"/> bladder problems
<input type="checkbox"/> poison oak or ivy
<input type="checkbox"/> fainting, dizziness or vertigo
<input type="checkbox"/> (females) normal menstrual history
<input type="checkbox"/> psoriasis
<input type="checkbox"/> hearing aid
<input type="checkbox"/> ear infection
<input type="checkbox"/> ear tubes | <input type="checkbox"/> Epilepsy
<input type="checkbox"/> Seizures
<input type="checkbox"/> Headaches
<input type="checkbox"/> Recent head injury
<input type="checkbox"/> Cancer
<input type="checkbox"/> Recurring pain(s)
<input type="checkbox"/> Recent surgeries
<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Arthritis/joint pain
<input type="checkbox"/> Warts
<input type="checkbox"/> Acne
<input type="checkbox"/> serious infections or other contagion
<input type="checkbox"/> surgical implants
<input type="checkbox"/> cerebral palsy
<input type="checkbox"/> Mobility issues (needs crutches, walkers or wheelchair)
<input type="checkbox"/> skin problems (eczema, rashes, itching)
<input type="checkbox"/> vomiting (stress, self-induced, gag reflex)
<input type="checkbox"/> wears orthodontic device, braces, headgear (etc)
<input type="checkbox"/> wears leg, knee or arm brace(s) or support device
<input type="checkbox"/> eating disorders (explain)
<input type="checkbox"/> hospitalized (reason)
<input type="checkbox"/> other behavior disorders (explain) | <input type="checkbox"/> History of running away
<input type="checkbox"/> depression
<input type="checkbox"/> history of violence
<input type="checkbox"/> autism
<input type="checkbox"/> indigestion
<input type="checkbox"/> knee injury
<input type="checkbox"/> back injury
<input type="checkbox"/> neck injury (explain)
<input type="checkbox"/> physical disability
<input type="checkbox"/> eyeglasses/contacts
<input type="checkbox"/> vision or hearing problems |
|---|--|---|

Explain *(use another sheet if necessary)*

<u>ALLERGIES (List all known)</u>	<u>Describe reaction</u>	<u>Treatment or Management of the reaction</u>
Medication Allergies		
Food Allergies		
Other Allergies (including latex, medical tapes or adhesives, etc)		

MEDICATIONS Currently being taken. Please list all routine medications including vitamin or food supplements, over-the-counter or non-prescriptive drugs. Bring enough medication to last the entire time at camp. Keep it in the original packaging that identifies prescribing doctor, name of medication, dosage and frequency of administration. Use additional sheet if necessary.

Medication name	Dosage (amount)	Times per day

Please **CHECK** all of the following types of non-prescription medication that you **AUTHORIZE** administration of by the camp nurse's discretion:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Pain reliever (Aspirin, Tylenol, Advil, Motrin) | <input type="checkbox"/> Antacids | <input type="checkbox"/> Antibiotic topical ointment | <input type="checkbox"/> Saline Nasal Spray |
| <input type="checkbox"/> Antihistamine/decongesting nasal spray | <input type="checkbox"/> Anti-nausea | <input type="checkbox"/> Insect repellent | <input type="checkbox"/> Eye drops/ointment |
| <input type="checkbox"/> Topical insect-bite or anti-itch medication | <input type="checkbox"/> Anti-diarrheal | <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Hydro-Cortisone Cream |
| <input type="checkbox"/> Non-antihistamine decongestant | <input type="checkbox"/> Cough medicine | <input type="checkbox"/> OTC Inhaler (Primatene) | <input type="checkbox"/> Laxatives |

IMMUNIZATION HISTORY Please give the dates of last immunization for the following (a copy of their immunization record is ok)

<u>Date</u>	<u>Vaccine</u>	<u>Has the participant ever had...?</u>	<u>Date</u>
	DTP	Measles	
	TD (tetanus/diphtheria)	Chicken Pox	
	Tetanus	German measles	
	Polio	Mumps	
	Measles (hard or red measles or rubeola)	Hepatitis (Type? _____)	
	Rubella	Shingles	
	Haemophilus influenza B	Tuberculosis	
	Hepatitis B		
	Varicella Zoster (chicken pox)		
	TB Mantoux test Results?		

DIETARY RESTRICTIONS (check ONLY those that apply)

ABSTAINS FROM Red Meat Poultry Seafood Pork Eggs Dairy Other
REQUIRES Vegetarian Vegan Kosher Halaal Other

Explain _____

Physical Limitations List all of the camper's physical limitations not mentioned above

Emotional Limitations List all recent family events that may have an impact on the camper's emotional experience (i.e. recent death in the family, divorce proceedings, foster care, molestation, rape, serious illnesses or cancer treatments, car accidents, burglaries, etc.) and indicate if this is the camper's first time away from home without family. This information will be kept in the strictest of confidence and is necessary for the nurse, staff and counselors to provide the camper with a supportive and empathetic environment and avoid any unnecessary discomfort on the part of the camper.

No prescription medication will be administered other than in strict accordance with the labeled physician's instructions. Failure or refusal of a child to allow administration of prescription medication will necessitate removal from the camp. It is understood that all medications except asthma inhalers will be turned over to the camp medical director who will make normal professional efforts to adhere to the recommended regimen.

_____ camper's initials _____ parent's initials _____ parent's initials

I AGREE THAT THE **CAMP MANAGER** (Red Cross First Aid certified) or **EMT** or the **CAMP MEDICAL DIRECTOR** may administer routine and emergency first aid and may in his or her sole judgment authorize transportation and emergency medical or surgical treatment by a physician or hospital or other qualified individuals).

I also agree that the Camp Medical Director or camp director **may send home** any child for medical reasons, and that the camp director has the discretion to remove any person for any reason **which jeopardizes the safety of any person or the peaceful conduct and enjoyment of the camp.**

_____ camper's initials _____ parent's initials _____ parent's initials

I know of no physical or psychological reason why my child cannot participate fully in all camp activities. I certify that to the best of my knowledge this history is complete and believe my child is in good physical condition except as noted and hereby release Sierra Mountain Music Camp the director the staff the nurse and all employees of the camp from medical liability.

I hereby authorize the physician, hospital or other qualified individual(s) contracted by the camp director or medical director to provide immediate medical dental or surgical care, x-rays, routine tests, release medical records including transportation and to bill my insurance for my son/daughter in any emergency which may occur at camp.

_____ parent's initials _____ parent's initials

Signature of parent/guardian Printed name Date

Signature of parent/guardian Printed name Date

I understand and agree to abide by the restrictions placed on my camp activities.

Signature of staffer, counselor or minor camper Printed name Date

Please Sign This Form and Return Immediately with Registration form and *signed* Camp Policy/Assumption of Risk contract to: Sierra Mountain Music Camp, P.O. Box 2881, Rancho Cordova, CA 95741-2881 **Thank You!**

*Sierra Mountain Music Camp does not discriminate on the basis of race, color, creed, national origin, sex, or physical disability in its admissions, financial aid, educational programs, activities or employment policies.

TRANSPORTATION INFORMATION

Sierra Mountain Music Camp does not accept responsibility for transportation to or from camp.

Complete this only if you want someone else to transport your camper.

The Activities Director will advise you of other campers from your area willing to share transportation.

Camper's Name

(DRIVER NAME)

Is authorized to transport camper TO CAMP

(DRIVER NAME)

Is Authorized to transport camper FROM CAMP HOME

Signature of Parent/Guardian _____

Telephone # _____

I have space in my car to transport another camper or staff member