CAMP QUARTERMAN (COLORADO)CAMPERS MUST COMPLETE

Child's Name

Camp Quarterman Participant Health Information/Physical Exam

(To be completed by the participant's parent/guardian and his/her doctor, physician assistant or nurse practitioner)

PRIMARY CARE INFORMATION			
Child's Physician	**Physician's Address**	**Physician's Telephone**	**Attach a copy of Insurance Card**
Child's Dentist	**Dentist's Address**	**Dentist's Telephone**	**Attach a copy of Insurance Card**

CHILD'S CARE NEEDS					
Height	Weight	Hair color	Eye color	Distinguishing marks	Date of Birth
Is there anything we should know about this child's care needs?					

ALLERGIES *Please list*	
Medications	Reaction
Food	Reaction
Respiratory	Reaction
Insect sting/bites	Reaction
Other	Reaction
Are any of the allergies severe or life-threatening? Yes_____No _____ **If yes, please provide special instructions:**	

REQUIRED IMMUNIZATIONS (please attach certificate of immunization or list immunization dates below)	
Diphtheria, Tetanus, Pertussi	Hepatitis B
Polio	Chickenpox
Measles, Mumps, Rubella	Other:

MEDICAL CONCERNS (check any of the following concerns pertaining to the participant's health)			
	A.D.D. / A.D.H.D. (bring usual meds to camp)		Hypertension
	Asthma		Migraines or other headaches
	Behavioral/emotional/psychiatric/psychological		Menstrual problems
	Convulsions/epilepsy		Muscular/skeletal
	Dental braces, retainer		Nose bleeds
	Diabetes/hypoglycemia		Respiratory
	Ear/sinus infections – chronic		Stroke/TIA
	Hearing		Urinary/kidney (UTI, etc.)
	Heart/circulation/blood disorder		Vision (other than glasses)
	Other:		
Please include details concerning all checked items above:			

Child's Name

Please describe any pertinent history of serious fractures, injuries, or illness:

Has this child been hospitalized or exposed to any communicable disease in the past three months?_____Yes_____No
If yes, please describe details of exposure:

MEDICATIONS (Prescription and Over-the-Counter)

All medications (except asthma inhalers and Epi-Pins) will be given to the center's nurse for dispensing. All medications must be in the original container. Prescription medication must have a pharmacy label.

Name of medication:	Dosage:	Time of Day:

RESTRICTIONS AND RECOMMENDATIONS

Special diet:

Restricted activity:

Other: (sleep apnea, sleep walking, fears/phobias, fainting, etc.)

I authorize Camp Quarterman staff and Cathedral Ridge staff to administer to my child topical non-prescription medications as needed, according to the dosage instructions on the medication container. For any other medication, if permitted by state child care licensing regulations or center policy, I will provide written authorization for Camp Quarterman staff and Cathedral Ridge staff to administer the medication in accordance with written instructions from the child's health care professional or me, as required. I will complete necessary authorization forms with my signature and understand prescription label dosage instructions must be followed. I will provide the medication in its original container with the pharmacist's label. I agree to provide any such medications, as these will not be provided by the center.

_____
Parent/Guardian Signature **Date**

I have examined this child and found her/him to be in satisfactory physical condition and capable of active participation in regular camp activities, except as noted above.

_____ _____ _____
Doctor's/Physician's Assistant/Nurse Practitioner's Signature **Phone #** **Date**

Child's Name

MEDICAL POLICIES

1. I understand that I will be asked to provide the center with updated immunization information for my child. If I wish to request a religious or medical exemption to Camp Quarterman and Cathedral Ridge's practice of securing immunization information, I understand my request must meet state child care licensing regulations.
2. I may also be asked to provide additional medical information as required by state child care licensing regulations. I understand that my failure to provide this information may result in a suspension of services.
3. I agree to promptly provide information to the center regarding any conditions, illnesses, allergies, or other special needs that may require specific care or attention and agree to provide additional documentation as needed.
4. If the center staff notifies me that my child is ill, I must pick up my child as soon as possible.
5. If my child contracts a reportable contagious disease, my child may return only with a physician/health care professional's note indicating that my child is no longer contagious.
6. In case of a medical or other emergency while my child is under the center's supervision, I understand that center staff will attempt to contact me immediately; however, in the event that I cannot be reached, or when a delay may further jeopardize my child's health, I hereby authorize center staff to act on my behalf and to take the emergency measures including those listed below if deemed necessary by center staff or by medical authorities for the care and protection of my child. I authorize Camp Quarterman and/or Cathedral Ridge to:
    - Consult the physician or dentist named on the previous page if I cannot be reached.
    - Administer first aid and/or cardiopulmonary resuscitation.
    - Transport my child via ambulance or other emergency medical service to a local hospital or other urgent care facility, if deemed necessary by paramedics, police, or other emergency personnel.
    - Obtain any emergency medical or dental treatment deemed necessary by medical authorities.
    - Transport my child to a local emergency shelter in the event of an emergency evacuation of the center.
7. If I wish to request a religious or personal exemption to Camp Quarterman and/or Cathedral Ridge's practice of securing necessary emergency medical treatment, I understand state child care licensing authorities must be consulted to determine if such an exemption may be granted.

Medication

Colorado State law requires strict control over medicines dispensed at camp. Therefore:

• All medication must be in its original container, clearly labeled with your child's name, medication name, dosage and name of the doctor issuing the prescription.

• All medication must be given to the camp nurse at registration. Medication in camp must be in a locked cabinet and dispensed by the camp nurse at the appropriate time according to the dosage marked on the container.

• Written record of all medication dispensed is required and no medication may be kept with the camper, including vitamins, aspirin, or food supplements. In cases of severe asthma, the counselor, under nurse's orders, will keep the medication.

• The camp nurse will dispense over the counter medication in accordance with the camp doctor's standing orders.

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The Episcopal Diocese of Northwest Texas

Cathedral Ridge – 1364 CR 75 – Woodland Park, CO 80863 719.687.9038 - office@cathedralridge.org
The Diocese of Colorado – 1300 Washington St. – Denver, CO 80203

Camp Quarterman Medical Information and Release of Treatment CHILD'S NAME_____

The Camp Infirmary keeps a stock of over-the-counter medications for use as needed. These are administered at the staff's discretion. Please check **ALL** that camper may receive.

____ Tylenol
____ Ibuprofen
____ Benadryl
____ Eye Drops
____ Imodium AD
____ Antacids
____ Pepto-Bismol
____ Hydrocortisone Cream
____ Throat Lozenges
____ Robitussin

All prescription medication must be turned in to the nurse upon check-in. Medication must be in original prescription bottle (or if OTC, must be in bottle/box and labeled).

This camp provides secondary medical coverage. Your frankness about any physical or emotional disability will help the staff to work more effectively with your child.

Emergency Contacts (other than parents which were listed on the camp registration form)

Name _____ Phone #s _____

Name _____ Phone #s _____

My child is healthy and capable of participation in this event without causing risk of danger, illness, or accident to him/herself or to others. I agree to hold harmless the leaders of my church, Camp Quarterman staff, volunteers and coordinators, the Bishop of Northwest Texas and the Episcopal Diocese of Northwest Texas in the event of injury or accident. I declare that my child is covered by medical insurance and/or I am responsible for any and all expenses incurred by my child whether covered by insurance or not. In the event that my child requires medical or dental attention, I understand that an adult sponsor will make every attempt to contact me. In the event that I cannot be reached, I consent to any medical attention deemed appropriate. In the event treatment is called for where the medical provider refuses to administer without my consent, I hereby authorize an adult sponsor to give such consent for me if I cannot be reached immediately or because of emergency there is no time or opportunity to make contact. In the event that it is necessary for that person to give consent, I agree to hold such person free and harmless of any liability for damages arising from giving such consent.

Parent/Guardian Signature _____ Date _____