



2010 CAMP CHOSÔN CAMPER/NURSERY HEALTH FORM

This form is to be completed by the Camper's parent(s)/guardian(s), signed by the Camper's Physician, and returned to our Medical Director post-marked no later than 5/31. **A completed form is required to attend camp.** All information is confidential and will be handled appropriately. Incomplete forms will be returned, and campers may be denied participation without a completed form on file. Send completed form to: Camp Chosôn Medical Director, 12 Lost Rock Lane, North Oaks, MN 55127; or e-mail to ferickson@comcast.net.

Camper & Parent Information:

_____ *Camper's Name: Last, First*

_____ *Nickname/Camp Name*

_____ *Birth Date*

_____ *Gender*

Check One: Nursery Day Camp Resident Camp

_____ *Street Address*

_____ *City*

_____ *State*

_____ *Zip*

_____ *Parent(s)/Guardian(s) Name(s)*

(_____) _____ *Home Phone*

(_____) _____ *Work Phone*

(_____) _____ *Cell Phone*

(_____) _____ *Additional Phone*

_____ *Other Adult(s) designated to pick up Camper (please list relationship to Camper also)*

(_____) _____ *Phone contact for other Adult(s)*

Emergency Contact Information:

_____ *Other than Parent(s)/Guardian(s) above, list another Adult as a Primary Contact and their Relationship*

(_____) _____ *Home/Work/Cell Phone*

_____ *Alternate Emergency Contact and Relationship to Camper*

(_____) _____ *Home/Work/Cell Phone*

Health History Information:

CURRENT MEDICAL ILLNESSES OR DIAGNOSES (Circle all that apply and list any others):

- | | | |
|------------------|-------------------------------|--------------------------------------|
| Diabetes | Emotional/Behavioral Disorder | Immunosuppression (specify) |
| Seizure Disorder | Bleeding/Clotting Disorder | List any Others (include surgeries): |
| Asthma | Sleep Walking | |
| Heart disease | Glasses/Contacts | |
| Skin Condition | Disability (specify) | |

ALLERGIES (Please list all that apply, or check the appropriate box):

Medication Allergies (None Known): _____

Insect Sting/Bite Allergies (None Known): _____

Food Allergies (None Known): _____

Other Allergies (None Known): _____

Please Describe the severity of the allergic reaction and how it is managed:

MEDICATIONS

This Camper does not take any medication on a routine basis.

(Please list all medications your camper takes, including vitamins or over-the-counter medications. Each camper must bring their own medications to camp. Resident Campers must bring enough for the week. All prescription medication must be in original container, properly labeled. Common nonprescription medications will be available from First Aid at camp.)

<u>Name of Medication</u>	<u>Dose</u>	<u>Frequency</u>	<u>Reason taking Medication</u>
---------------------------	-------------	------------------	---------------------------------

Provider Information:

<hr/> <i>Name of Camper's Physician and Clinic</i>	(_____)_____ <i>Phone</i>
--	------------------------------

<hr/> <i>Name of Camper's Dentist/Orthodontist and Clinic</i>	(_____)_____ <i>Phone</i>
---	------------------------------

Health Insurance:

Parent(s)/Guardian(s) are financially responsible for health care given by an out-of-camp provider should one be necessary.

<hr/> <i>Name of Insurance Provider/Company</i>	<hr/> <i>Policy/Group Number</i>	<hr/> <i>Camper's Identification Number</i>
---	----------------------------------	---

Physician Statement (this section not required for children in the nursery):

Each Camper must have had a physical examination within 24 months prior to camp to determine physical fitness and be able to participate. By signing this, the physician verifies that: he/she is a licensed physician; this Camper has had a physical exam more recently than 6/30/08; the record of the exam is on file at the physician's office/clinic; the Camper named above is physically and emotionally able to participate in routine summer camp activities (please note any exceptions below); the Camper's immunizations are up to date; and, the Health History Information listed above is accurate.

Please list date of last exam, any exceptions to the above statement, and any restrictions of activity: _____
Date of Last Exam

<hr/> <i>Physician Name - Please Print</i>	<hr/> <i>Signature</i>	<hr/> <i>Date Signed</i>
--	------------------------	--------------------------

PARENT/GUARDIAN AUTHORIZATION: To the best of my knowledge the information contained on this form is correct. The Camper named above has permission to participate in all camp activities except as noted by me and/or the Camper's Physician. I give permission to the Girl Scout Council of St. Croix Valley (GSCSCV) personnel, or designated volunteers of Camp Chosôn, to provide treatment and medications for my child, including administration of the medications listed above, in accordance to the information contained within. In the event I cannot be reached in an emergency, I give permission to the physician selected by GSCSCV personnel or designated volunteers of Camp Chosôn, to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child. I agree to hold harmless the Girl Scout Council of St. Croix Valley, the St. Croix Valley Korean-American Cultural Society, staff, counselors and designated volunteers from any and all losses and/or accidents, however caused, and agree to release all parties involved from claim or damage that may arise as a result of such loss or accident.

Unless this box is checked, I acknowledge that my child may be included in photographs taken during camp when normally participating in activities, classes or any other part of camp life, and **give my permission** for such photographs to be used (without identifying information included) in promotional material created by Camp Chosôn to include the web site.

<hr/> <i>Signature of Parent(s)/Guardian(s)</i>	<hr/> <i>Date</i>
---	-------------------