# *Camp Maxwelton – Camp Lachlan*

***Health Medical Record***

**Part 1: To Be Completed by Parents (please print or type)**

Camper's Full Name _____Birth Date_____

Parent(s) Name(s) _____

Address _____, _____, _____ _____

Phone(s) _____

Emergency Contact _____ Address (City, State) _____, _____

Phone_____ Relationship to Camper _____

Will parents be traveling during Camp? YES NO
If so, please provide additional trip/contact information. _____

Does camper wear braces, retainer, headgear, or other orthodontic wear? YES NO
If so, please explain. _____
Name of Orthodontist/Dentist _____ Phone _____

Does camper wear glasses or contact lenses? YES NO If so, please explain. _____

Our counselor staff is not trained to manage the special needs of children with diagnosed physical and/or mental conditions including, but not limited to: ASD, severe ADHD, severe depression, seizure disorders, eating disorders, bipolar disorder, schizophrenia, etc. Please answer the following questions as honestly and accurately as possible to help us best meet the needs of your child.

Does your child see a mental health professional regularly? YES NO
If so, how often and in what capacity? _____
_____

Does your child attend physical therapy regularly? YES NO
If so, how often and in what capacity? _____
_____

Does your child have any physical limitations or behavioral issues or needs that we should be aware of? YES NO
If so, please explain. _____
_____

Has your child had any recorded behavioral infractions at his or her school in the last two years? YES NO
If so, please explain. _____
_____

If there is anything else that would help us best meet the needs of your child, please let us know. (e.g. a recent move, a death in the family, divorce, medical diagnosis of self or a family member, extreme trauma, bullying, fear of storms or blood, bed wetting (it's ok!), sleep issues)

_____
_____
_____

*I have answered these questions fully and accurately.*

Parent Signature: _____ Date: _____

IMPORTANT: Please notify the Directors if your child is exposed to any communicable disease during the three weeks prior to arriving at Camp. If your child is sick before Camp, he/she must be fever-free for 24 hours before drop off.

REMINDER: Please check your child for head lice before drop-off.

If there are any further concerns, conditions, dynamics, or needs you feel are pertinent to our best preparation for and care of your child, or should you prefer to discuss any of this over the phone, please don't hesitate to call LeeBo and Nancy at 540-348-1090 (home), 540-460-0522 (LeeBo cell), or 540-460-5327 (Nancy cell), or email directors@maxwelton-lachlan.com.

## PARENTS' CONSENT TO TREATMENT

I hereby give permission to the physician selected by the Camp Director to order x-rays, routine tests, and treatment for my child. In the event that I cannot be reached in an emergency, I give permission to the physician selected by the Camp Director to hospitalize, to secure proper treatment for, and to order injections and/or anesthesia and/or surgery for my child. I understand that should my child be hospitalized; all hospital bills and related doctor expenses will be sent to me or to my family medical insurance carrier for payment.

Parent Signature: _____ Date: _____

**Please include a photocopy of the front and back of your insurance card**

**Part 2: To Be Completed by Family Health Care Provider (please print or type)**

Camper's Full Name _____Birth Date_____

Are Immunizations up to date? YES NO If "No" what needs to be monitored? _____

Date of last Tetanus Shot _____

## ALLERGIES/ASTHMA

Food Allergies YES NO If yes, to what? _____
What type of reaction? _____
Treatment Plan if Exposed _____

Drug Allergies YES NO If yes, to what? _____
What type of reaction? _____

Other Allergies YES NO If yes, to what? _____
What type of reaction? _____
Treatment Plan if Exposed _____

Does camper suffer from asthma? YES NO Is asthma mild, moderate, or severe? _____
What triggers asthma reaction? _____ Approximate date of last attack _____
What is the current medication and treatment plan? _____

## MEDICATIONS

Prescription 1: _____
Diagnosis _____ Dosage _____

Prescription 2: _____
Diagnosis _____ Dosage _____

Prescription 3: _____
Diagnosis _____ Dosage _____

OTC 1: _____
Diagnosis _____ Dosage _____

OTC 2: _____
Diagnosis _____ Dosage _____

OTC 3: _____
Diagnosis _____ Dosage _____

Special instructions for any medications to be administered at camp:

_____

_____

**SPECIAL NEEDS**

Physical limitations (permanent or temporary)? YES NO
If yes, please explain.*_____

Social/emotional/behavioral concerns? YES NO
If yes, please explain.* _____
_____

*Please note that our counselors are not trained to handle physical/behavioral/social/emotional issues or needs beyond the scope of a traditional learning environment.

(name of Camper) _____ has been examined by me and has been found fit to take part in all camp activities.

Signature of Health Care Provider _____ Date_____

Health Care Provider Printed Name_____

Address_____, _____, _____ _____

Phone_____