The Cathedral Domain **Name of Camp Session_____**

Camp and Conference Center
830 Highway 1746 -- Irvine, KY 40336-8701

Date of camp_____/____/_____

Return by the following date: _____/_____/_____

Medical Release Form and Permission to Treat

For Resident Camp Use.
The Health history and examination must be updated annually. A Licensed medical professional must complete the health examination.

Name_____Birthdate_____

Age at camp_____ S.S.# number of camper _____-_____-_____

Home address_____ Phone #_____

_____

Gender of camper (circle) Male Female

Custodial parent/guardian _____

Home address (if different than above) _____

Business address_____

Contact phone numbers (cell, business) _____

If not available in emergency, notify _____

Relationship to camper_____ Phone #_____

Insurance information: Is the camper covered by medical/hospital insurance? ___

****Copy front and back of insurance card and attach to this form. ****

Family physician_____ Phone #_____

Family dentist_____ Phone #_____

****

The information on this form is not part of the camper or staff acceptance process but is gathered to assist us in providing appropriate care. Any changes to this form should be given to camp health personnel upon participant's arrival at camp.
Provide complete information so that the camp can be aware of your/your child's needs.

LIST ALLERGIES AND DESCRIBE REACTIONS:
Medication: _____
Food: _____
Other: (insect stings, environmental, etc.) _____

Diet/Nutrition
___ camper eats a regular diet ___ Camper eats a regular vegetarian diet
__ Special food needs_____

LIST ALL MEDICATIONS TO BE GIVEN AT CAMP: (OVER THE COUNTER AS WELL AS VITAMINS OR SUPPLEMENTS) **BY LAW, NO PRESCRIPTION MEDICATIONS WILL BE GIVEN UNLESS IN THE ORIGINAL LABELED BOTTLE WITH THE CAMPER'S NAME, PRESCRIBER'S NAME, NAME OF MEDICATION, DOSAGE AND INSTRUCTIONS FOR ADMINISTRATION. NO PROFESSIONAL SAMPLES WITHOUT PRESCRIBER LABEL.
____This camper takes no medications.
____This camper takes the following medications on a routine basis.
Medication _____Dosage_____
Times taken each day _____Reason_____
Medication _____ Dosage _____
Times taken each day _____Reason _____
Other_____
Medication _____ Dosage _____
Times taken each day _____Reason _____
Other_____
Medication _____ Dosage _____
Times taken each day _____Reason _____
Other_____

Past Medical History: List hospitalizations, serious or chronic conditions and any injuries that required medical intervention in the past 5 years. _____
_____
_____

****

EMERGENCY AUTHORIZATION: The health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine first aid, administer prescribed medications and seek emergency medical treatment including x-rays or interventions as deemed necessary. I also grant permission to the licensed provider selected by this camp to hospitalize, secure proper treatment, order injections and/or anesthesia and/or surgery as judged appropriate for the situation. I further authorize the release of medical information to any provider, insurance company and medical facility that may need access to complete their care. I have, and do hereby, release The Cathedral Domain, its employees or agents from liability associated with participation in camp activities. I understand that if I do not have medical insurance, I, as the participant/parent/ guardian, will be responsible for any medical expenses in the event of illness and/or injury. I understand that there are risks involved in participating in a residential camp and its activities. There has been a well examination of this camper within the last two years.

Emergency Authorization Granted_____ Emergency Authorization Denied _____

****SIGNATURE OF PARENT/GUARDIAN_____**

PRINTED NAME_____DATE_____

Please circle any of the following conditions that apply to the participant:

Asthma
Passed out after exercise
Seizures
Back Problems
Eating disorder
Frequent ear infections
Diabetes
Surgery of any type
Hospitalized
Bed-wetting
Infectious disease
Heart Murmur
Skin problems
High blood pressure
Frequent headaches
Joint pain
Head injury

Please explain any circled answers_____
_____
_____

Has the participant had mononucleosis in the past year? ____Yes ____No

If female, has the participant had an abnormal menstrual history? ____Yes ___No ___N/A

Has the participant ever had emotional difficulties where professional help became necessary? _____Yes _____No

Circle the following that the participant has had?
Measles, Mumps, Chicken Pox, German Measles, Hepatitis A, Hepatitis B, Hepatitis C.

Are immunizations up-to-date? _____ If not, explain _____

Last tetanus injection if known_____/_____/_____

Last TB skin test: (N/A ___) _____/_____/_____ Result? _____

Mental, Physical, Emotional, and Social Health

___ Camper has been treated for (ADD) Attention Deficit Disorder

___ Camper has been treated for (ADHD) Attention Deficit/Hyperactivity Disorder

___ Camper has been treated for emotional or behavioral difficulties or an eating disorder

___ Camper has seen a professional to address mental/emotional health concerns

___ Camper involved in a significant life event *(History of abuse, death of a loved one, death of a pet, family change, adoption, foster care, new sibling, survived a disaster)*

Anything else we should know?

Any activities that the camper should be exempted from?

****SIGNATURE OF PARENT/GUARDIAN_____DATE_____**

Page 4 Health Care Recommendations by Licensed Medical Personnel

Camper's Name _____

I examined this individual on _____
(ACA accreditation requirements specify well exams within 12 months of camp attendance.)

Height _____ Weight _____ B/P _____/_____

In my opinion, the above applicant ___(is) ___(is not) able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

Recommendations and Restrictions at Camp:

Treatment to be continued at camp: _____

Medications to be administered at camp (name, dosage, frequency) _____

Any medically prescribed meal plan/dietary restriction: _____

Known allergies:

Description of any limitation or restriction on camp activities:_____

Additional information for health care staff at the camp:_____

SIGNATURE OF LICENSED MEDICAL PERSONNEL_____
Printed_____Title_____
Address_____
Phone _____Date _____
