Logan Ranch Camp
Camper Health & Insurance Form

Name: _____
LAST FIRST/Middle Maiden

We need to have an emergency contact name and number, along with a copy of your current insurance information. This will only be used if you are taken for medical treatment.

In case of emergency contact:_____Relationship _____

Name:_____

Phone:_____email:_____

Address:_____

City/Zip: _____

MEDICATIONS

Will you be taking medications while at camp? ❍ Yes ❍ No (include prescription, over the counter, vitamins, inhalers, etc.)

All medications, including over the counter are turned in at registration and will be locked in the first aid cabinet. Adults will need to speak with the person designated first aid or the director to get their medications from the first aid cabinet.
Initials X _____

Prescription Medications – Over the Counter Medications – Please put all medications and an updated prescription list in a Ziploc bag with your name. All medications MUST be in an original prescription container with the name, physician, and dosage directions on the label. We cannot dispense medications unless in the proper container. Check with your pharmacy for a labeled container. Only bring enough medication for the duration of the event. If you are sending over-the counter medications, please provide an un-opened container.

Please list below all prescription and non-prescription medications you are bringing. Include the medication name, prescribing physician, physicians' phone number and the dosage instructions. Use an additional sheet if needed.

Medication Name	Medication Name	Medication Name
Dosage	Dosage	Dosage
Frequency – check all that applies. ❍ Breakfast ❍ Lunch ❍ Dinner ❍ Night ❍ As Needed	Frequency – check all that applies. ❍ Breakfast ❍ Lunch ❍ Dinner ❍ Night ❍ As Needed	Frequency – check all that applies. ❍ Breakfast ❍ Lunch ❍ Dinner ❍ Night ❍ As Needed
# pills in container	# pills in container	# pills in container

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# pills in container	# pills in container	# pills in container

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Are there any medications that should not be given while at camp? ❍ Yes ❍ No Please list._____

_____

Physician's Name:_____Phone_____

Dentist/Orthodontist Name:_____Phone_____

INSURANCE INFORMATION

ARE YOU COVERED BY MEDICAL/HOSPITAL INSURANCE? ❍ Yes ❍ No Please include a copy of insurance cards.

Insurance Carrier:_____Policy #:_____Group #:_____

Policy Holder's Name:_____Relationship to participant:_____

Billing Address:_____

ALLERGIES Do you have allergies? ❍ Yes ❍ No

❍ Hay Fever ❍ Poison Ivy/Oak ❍ Insect Stings ❍ Penicillin ❍ Other Drugs _____

❍ Other Allergy_____

List Allergies, describe reaction and treatment _____

HEALTH HISTORY

Please know we value your privacy. Health History information is available only to the designated first aid staff. The more information you provide, the better we can do our job. Thanks!!

Do you have a history of or prone to any of the following? Please check all that apply.

❍ 1. Recent injury, illness, infectious disease
❍ 2. Chronic or recurring illness
❍ 3. Asthma
❍ 4. Homesickness
❍ 5. Frequent Ear Infections
❍ 6. Seizure Disorder or Convulsions
❍ 7. Dizziness during or after exercise
❍ 8. Chest pain during or after exercise
❍ 9. Heart Defect/Disease
❍ 10. Hypertension
❍ 11. Bleeding/Clotting Disorders
❍ 12. Diabetes
❍ 13. Mononucleosis (in last 12 months)
❍ 14. Chicken Pox
❍ 15. Measles
❍ 16. German Measles
❍ 17. Mumps
❍ 18. Tuberculosis
❍ 19. Hepatitis
❍ 20. Joint problems (knees, ankles)
❍ 21. Been hospitalized
❍ 22. Frequent Headaches
❍ 23. Head Injury
❍ 24. Eating Disorder
❍ 25. Diarrhea or constipation
❍ 26. Frequent Stomachaches
❍ 27. Wears glasses or contacts
❍ 28. Attention deficit disorder (ADD)
❍ 29. Attention deficit/hyperactivity disorder (AD/HD)
❍ 30. Fainting

Please list the number and provide explanation of any checked items.

_____

_____

_____

DIETARY/ALLERGIES

Do you have dietary restrictions? ❍ Yes ❍ No Do you have food allergies? ❍ Yes ❍ No

Gluten-Free? ❍ No ❍ Yes, If Yes, is it medical or a preference? _____	Are you a: Vegetarian? ❍ No ❍ Yes Picky Easter? ❍ No ❍ Yes Do you eat meat? ❍ No ❍ Yes
Known allergies to food? (allergens, such as peanuts and other nuts may be used and you might come in contact with these allergens) ❍No ❍ Yes If yes, please list.	
Additional remarks regarding dietary/allergies.	