PRE-SCREENING HEALTH FORM

ORGAZATION____

DATE OF CAMP____

NAME OF CAMPER/STAFF____

1. HAS CAMPER/STAFF EXHIBITED SYMPTOMS SUCH AS NAUSEA, VOMITING, OR DIARRHEA WTIHIN THE LAST 24 HOURS? YES__________ NO___________
2. DOES THE CAMPER/STAFF HAVE AN ELEVATED TEMPERATURE, OVE 100F? YES_______________ NO__________________
3. DOES THE CAMPER/STAFF DISPLAY OTHER TRANSMISSIBLE CONDITIONS(LICE, PINK EYE, ETC)? YES______________NO___________
4. HAS THE CAMPER/STAFF BEEN RECENTLY EXPOSED (WITHIN LAST 48 HOURS) TO FAMILY MEMBERS WHO HAVE EXHIBITED ANY SYMPTOMS OR ILLNESS AS DESCRIBED ABOVE? YES________________NO____________ IF SO, THESE STAFF OR CAMPERS CAN BE MONITORED MORE CLOSELY AT CAMP.

SIGNED CAMP NURSE OR STAFF WHO PREFORMED PRE-SCREENING

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Camp Metoche

Emergency Information & Authorization to Treat

Adults at camp

Camper Name ____________________

Birth Date ____________________ Age at Camp ________

Female ☐ Male ☐

Cell Phone ____________________ Home Phone ____________________

Email Address ____________________

Mail Address ____________________

Emergency Contacts:

Contact#1 ____________________

Relationship ____________________ Email Address ____________________

Cell Phone ____________________ Home Phone ____________________

Contact#2 ____________________

Relationship ____________________ Email Address ____________________

Cell Phone ____________________ Home Phone ____________________

Please attach a copy of health insurance card (front & back)

Camper is covered by medical/hospital insurance ☐ Yes ☐ No

Company Name ____________________ Policy# ____________________

Family physician ____________________ Phone# ____________________

Family dentist ____________________ Phone# ____________________

Food allergies/intolerance ____________________

Drug allergies/intolerance ____________________

Other allergies/intolerance ____________________

Current health/medical conditions ____________________

Treatment required at camp ____________________

Current medications (RX, OTC, food supplements) ____________________

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IMPORTANT - The following must be complete for attendance at camp

☐ The information on this form is complete and correct to the best of my knowledge. I hereby give permission for the camp staff to provide routine health care and emergency medical treatment, including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp staff to arrange necessary related transportation. In the event of an emergency, I hereby give permission to the physician selected by the camp staff to secure and administer treatment, including hospitalization.

☐ I hereby exercise my right to refuse to provide medical information. I understand that this choice may make it impossible for the camp staff to provide appropriate medical care if I become unconscious or unable to make medical decisions on my own.

Signature ____________________ Date ____________________

Camper Name ____________________

Cabin ____________________

Camp Dates ____________________