GREAT SMOKY MOUNTAINS INSTITUTE AT TREMONT

Camp Attending: _____

Date of Camp: _____

2016 Summer Camp Medical Information and Waiver

STEPS for Parents/Guardians:

1. Fill out pages 1 and 2 of this form. You must sign and date page 2. It is your responsibility to complete this form. Any missing information may potentially jeopardize the health of your child in case of an emergency.

2. Ask your child's physician to fill out page 3. Your examining physician must sign and date page 3. *A medical examination is required within two years prior to the camp's starting date.*

3. Return all 3 pages by the specified deadline.

Please Note: Tremont is required to retain a copy of this form for our records. The information on this form will remain confidential. Names and addresses will be added to our mailing list but not released to any other organization.

>> PLEASE USE BLACK INK <<

Camper's Name _____ Gender _____ Race _____ (*for reporting only*)

Parents / Guardians _____

Home Address _____City _____State _____Zip _____

Home Phone (_____) _____

Please list parents' / guardians' additional information below:

_____'s Work Phone (_____) _____ Cell (_____) _____
(name)

_____'s Work Phone (_____) _____ Cell (_____) _____
(name)

Best number for reaching parent or guardian when child is at Tremont (_____) _____

If the above are not available for an emergency, notify:

1st alternate: Name _____Phone (_____)_____ Relationship to Camper:_____

2nd alternate: Name _____Phone (_____)_____ Relationship to Camper:_____

Is this child covered by medical/hospital insurance? _____ Your insurance carrier_____

Group # _____ Policy # _____

What is your physician's name? _____ Phone (_____)_____

Dentist/orthodontist _____ Phone (_____)_____

Has the camper had any serious illness/injury? _____

Does the child ever have any chronic or recurring illnesses? _____

Has the camper undergone surgery? (include dates) _____

If necessary, do we have your permission to give the camper:

Acetaminophen? Yes ___ No ____ Ibuprofen? Yes ___ No ____ Benadryl? Yes ___ No ____

Is the camper allowed to swim? Yes _____ No_____

Are there any activities that should be restricted for this camper?_____

Does the camper require any special dietary needs? _____

What is your child's level of experience going away to camp? _____

HEALTH HISTORY *(Check all that apply, if necessary giving approximate dates and details below or on another sheet.)*

___ Frequent ear infections ___ Heart Defect/Disease ___ Convulsions

___ Bleeding/Clotting Disorders ___ Diabetes ___ Asthma

___ Insect Sting Allergy (How severe? _____)

___ Food Allergy (please list: _____)

Allergic to: ___ penicillin ___ sulfa ___ other medications (please list: _____)

For females: Has the camper menstruated? Yes ____ Is her menstrual history normal? Yes ____ No ____

No _____ Has she been told about it? Yes _____ No _____

LIST ALL MEDICATIONS YOU ARE SENDING WITH YOUR CHILD TO CAMP:

Medication	Dosage	Taken (Breakfast, lunch, supper, bedtime, other)

Are there helpful accommodations that have aided your child in the past? _____

_____

Does your child have any emotional, physical or mental challenges/limitations? _____

_____

Please describe how your child's particular challenges/limitations present themselves in a group setting: _____

_____

PARENT'S AUTHORIZATION - This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted by the examining physician and me. I hereby give permission to the physician selected by the camp director to order X-Rays, routine tests, and treatment for the health of my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above.* It is expressly understood and agreed that GSMIT shall not be responsible or legally liable for any losses of personal property or for any bodily injuries, or the results thereof, incurred and suffered by the applicant or in connection with any activities or programs, unless such loss or injury results directly from the negligent or willful act of an employee of GSMIT acting within the scope of his/her employment. I grant permission to the Institute to use my child's image, likeness or quotes in publications for the purpose of advertising.

Signature _____ Date: _____

PHYSICIAN'S REPORT

IMMUNIZATION HISTORY – *IMMUNIZATIONS MUST BE CONFIRMED BY YOUR FAMILY DOCTOR OR LOCAL HEALTH DEPARTMENT.*

VACCINES	DATE OF BASIC IMMUNIZATION	DATE OF BOOSTER
DPT (Diptheria, Pertussis/ Whooping Cough, Tetanus)		
Tetanus		
Oral Polio (Sabin) TOPV		
Injectable Polio (Salk)		
Measles (hard, red, Rubella)		
Mumps		
Rubella (German measles, 3-day)		
Other		
Tuberculin test		
Haemophilus influenza b (HIB)		
Hepatitus B		
Chicken Pox		

MEDICAL EXAMINATION - To be filled out and signed by a licensed physician. **A medical examination is required within two years of the camp's starting date. Participants without a complete medical form will not be admitted to the program.** Examination is for determining fitness to engage in strenuous activities.

CODE: V=Satisfactory; X=Not Satisfactory (Explain); O=Not examined

___ Eyes	___ Heart	___ Hernea	___ Allergy (please specify)
___ Glasses	___ Genitalia	___ Extremities	_____
___ Ears	___ Hct. or Hgb. Test	___ Posture (spine)	_____
___ Nose	___ Lungs	___ Skin	_____
___ Throat	___ Abdomen	___ Urinalysis	_____

Height _____ Weight _____lbs.

General Appraisal: Excellent _____ Good _____ Fair _____ Poor _____

RECOMMENDATIONS AND RESTRICTIONS WHILE IN CAMP:

Activities to be encouraged? _____ Activities to be limited? _____

Emotional or behavioral problems? _____

Special diet? _____

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I HAVE EXAMINED THE PERSON HEREIN DESCRIBED AND HAVE REVIEWED THE HEALTH HISTORY. IT IS MY OPINION THAT THIS CAMPER IS PHYSICALLY ABLE TO ENGAGE IN CAMP ACTIVITIES, EXCEPT AS NOTED ABOVE.

Physician _____ Date _____ Phone (_____) _____

Address _____City_____State_____Zip _____

Return to: GREAT SMOKY MOUNTAINS INSTITUTE AT TREMONT
9275 Tremont Road
Townsend, TN 37882
Fax: 865-448-9250
mail@gsmit.org

For Staff Internal Use Only:
Initial and date here following health assessment, within 24 hours of camper's arrival:
Initial: _____ *Date:*_____