

(For Camp Use) Group \_\_\_\_\_

## Camp Blue Spruce Medical Form - 2016

Please return to camp by **May 1** with your final payment. This is a fillable pdf form. Please download, save to your computer, complete, save and email to [info@CampBlueSpruce.org](mailto:info@CampBlueSpruce.org). (Please note your camper's name in the email title.) Or, print the form and mail to: 3519 NE 15<sup>th</sup> Ave., Box # 225, Portland, OR 97212.

We recommend that you visit your allergist or primary care doctor before coming to camp, so we have current medications and health information.

You may be contacted before camp to discuss your camper's allergies and other medical needs. During camp check-in on August 21, *a parent/guardian and your camper must meet with the camp physicians*. If this is not possible, arrangements must be made with the Camp Blue Spruce Medical Team one week prior to camp. To make special arrangements contact the office at 503-726-8886.

**Camper's Name:** \_\_\_\_\_

**First Parent or Guardian Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

**Second Parent or Guardian Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

### Emergency Contacts – Other than Parent or Guardian

Name	Relationship	Day Phone	Evening Phone	Cell Phone
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_____	_____	_____	_____	_____
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_____	_____	_____	_____	_____
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Name of Primary Care Doctor and Clinic: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Name of Allergist and Clinic: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Name of Dentist/Orthodontist: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Insurance Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

Group ID #: \_\_\_\_\_ Subscriber #: \_\_\_\_\_

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**HEALTH INFORMATION – VITALS**

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Weight: \_\_\_\_\_ lbs Height: \_\_\_\_\_ ft \_\_\_\_\_ in

Date of last physical (month/day/year): \_\_\_\_\_

This participant is allergic to the following medication(s): \_\_\_\_\_

\_\_\_\_\_

This participant is allergic to the following non-food substance(s):

\_\_\_\_\_

Describe the reaction and what is done to manage the reaction (attach additional information if needed):

\_\_\_\_\_

**Immunizations** – Please check the box next to any immunizations your camper has had:

- ☐ DTP (Diphtheria, Tetanus, Pertussis/Whooping Cough)
- ☐ Td (Tetanus booster)
- ☐ MMR (Mumps, Measles, Rubella)
- ☐ IPV/OPV (Polio)
- ☐ Hepatitis B
- ☐ Haemophilus influenza B (Flu)
- ☐ Tuberculosis
- ☐ Varicella (Chicken Pox)

Does your child have any physical limitations? Camp days are long and physically demanding.

☐ No      ☐ Yes, please explain:

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**FOOD ALLERGIES**

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**When were the camper's food allergies or celiac disease diagnosed?**

**When was the most recent allergic reaction?**

Please complete the following chart with detailed information about your child's food allergies:

Food	Describe the reaction if this food is eaten and what is done to manage the reaction:	Do you carry epinephrine for this allergy? YES or NO

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## HEALTH HISTORY

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**Please check** the box next to any condition/problem/event your camper has had. On a separate piece of paper or in the area below, please provide details (dates/reasons/procedures) about any or all that apply.

- ☐ Hospitalized? List all dates/reasons
- ☐ Surgery? List all dates/procedures
- ☐ Recurrent/chronic illness? Describe
- ☐ Recent injury? Describe
- ☐ Asthma/wheezing/shortness of breath? Describe treatment
- ☐ Diabetes? Describe condition and treatment
- ☐ Exposure to any known infections other than routine cold viruses? Provide details
- ☐ Seizures? Describe condition and treatment

- ☐ Known heart condition or arrhythmias? Describe condition and treatment
- ☐ Headaches? Describe type/severity and treatment
- ☐ Fainting or dizziness? Describe condition and treatment
- ☐ Chest pains? Describe condition and treatment
- ☐ Head injury? Describe cause/treatment
- ☐ High blood pressure? Describe condition and treatment
- ☐ Passed out/had pain during exercise? Describe condition and treatment
- ☐ Mononucleosis (mono) during the past 12 months? Provide details
- ☐ If female, problems with periods/menstruations? Describe condition and treatment
- ☐ Traveled outside the country in the past 9 months? Provide details
- ☐ Back/joint problems? Describe condition and treatment
- ☐ Social or Emotional challenges? Please describe
- ☐ Behavioral challenges, such as impulsivity, anger management or difficulty following instructions?
- ☐ Problems with diarrhea/constipation? Describe condition and treatment
- ☐ Skin problems? Describe condition and treatment
- ☐ History of bedwetting?
- ☐ Problems falling asleep? Describe how you handle this
- ☐ Problems sleepwalking? Describe condition and treatment
- ☐ Wear glasses, contacts or protective eye wear? Describe
- ☐ Have an orthodontic appliance being brought to camp? Describe
- ☐ Have autism, or is on the autism spectrum, or is being evaluated for autism spectrum disorder?  
Describe

**Please elaborate on any of above issues or add a separate sheet of paper:**

- ☐ **Despite the issues described, this participant is capable of full program participation**
- ☐ **Because of these issues/limitations/events, this participant should not participate in the following activities (e.g. swimming or hiking):** \_\_\_\_\_
- ☐ **This participant has no chronic health concerns, other than food allergies, and is capable of full participation in this program**

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## OTHER CAMPER INFORMATION

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The following questions are designed to help us work with families before each camper arrives at camp. Please attach any other information that will help us prepare for your child's attendance.

What are your child's strengths?

What are your child's challenges?

Describe your child's friendship style:

- ☐ Lots of friends
- ☐ Tends to keep to self
- ☐ Few friends
- ☐ Other \_\_\_\_\_

Has your child ever spent an extended time away from the family before? If so, were there any problems that arose in terms of homesickness, or behavioral concerns? If not, do you think your child would be comfortable participating and living with many other children in a setting like Camp Blue Spruce?

Does your child have an Individualized Education Program (IEP)? If so, please indicate types of recommendations/services outline in the IEP.

Please indicate if your child has received any of the following services within the last 3 years:

- |   |  |
|---|--|
| <input type="checkbox"/> Speech Therapy       | <input type="checkbox"/> Behavioral Therapy    |
| <input type="checkbox"/> Physical Therapy     | <input type="checkbox"/> Mental Health Therapy |
| <input type="checkbox"/> Occupational Therapy |  |

Have these therapies been helpful? Please explain.

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## MEDICATION

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All medication must be delivered to our nursing staff in the original container (prescription and over-the-counter medication and/or supplements). No medication will be accepted if it is not provided in its original container.

Prescription medication must have an accurate label. This includes samples given by a physician. If the directions on the label differ from current dosing, written instruction from the prescribing physician is required.

We are not able to accept or administer over-the-counter medications and/or vitamins/supplements without a doctor's written permission.

☐ This camper will not be bringing any medication to camp including prescribed medications, over the counter medications, auto injectors and/or inhalers.

☐ This camper is bringing the following medications to camp. Please provide all requested information in detail.

### Epinephrine:

☐ This camper has an epinephrine auto injector.

Brand: \_\_\_\_\_ Dose: (adult/Jr): \_\_\_\_\_

☐ I would like my child to carry his/her auto injector while at camp (see note below).

\*\*Parent or guardian signature: \_\_\_\_\_

### Inhaler:

☐ This camper has an **inhaler**.

Brand: \_\_\_\_\_ Dose (# puffs): \_\_\_\_\_

Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐

Other, please describe: \_\_\_\_\_

☐ I would like my child to carry his/her inhaler while at camp (see note below).

\*\*Parent or guardian signature: \_\_\_\_\_

Note: Camp Blue Spruce's safety protocols are designed to allow campers to move about camp freely and safely without the burden of carrying emergency medications. However, if your child prefers to carry his/her own medication and is able to do so responsibly, we can accommodate this need.

**Medication 1**

1) Name of Medication: \_\_\_\_\_ 2) Date Started: \_\_\_\_\_

3) Dosage: \_\_\_\_\_ 4) How is it given? \_\_\_\_\_

5) Time of Day: ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime☐ Other, please describe: \_\_\_\_\_

6) Reason for Taking: \_\_\_\_\_

**Medication 2**

1) Name of Medication: \_\_\_\_\_ 2) Date Started: \_\_\_\_\_

3) Dosage: \_\_\_\_\_ 4) How is it given? \_\_\_\_\_

5) Time of Day: ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime☐ Other, please describe: \_\_\_\_\_

6) Reason for Taking: \_\_\_\_\_

**Medication 3**

1) Name of Medication: \_\_\_\_\_ 2) Date Started: \_\_\_\_\_

3) Dosage: \_\_\_\_\_ 4) How is it given? \_\_\_\_\_

5) Time of Day: ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime☐ Other, please describe: \_\_\_\_\_

6) Reason for Taking: \_\_\_\_\_

**Medication 4**

1) Name of Medication: \_\_\_\_\_ 2) Date Started: \_\_\_\_\_

3) Dosage: \_\_\_\_\_ 4) How is it given? \_\_\_\_\_

5) Time of Day: ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime☐ Other, please describe: \_\_\_\_\_

6) Reason for Taking: \_\_\_\_\_

The following non-prescription medications are commonly stocked in camp Health Centers and are used on an as needed basis to manage illness and injury. ***Please mark those items the camper should NOT be given.***

<b>NO</b>	<b>NO</b>
<input type="checkbox"/> Acetaminophen (Tylenol)	<input type="checkbox"/> Calamine lotion
<input type="checkbox"/> Ibuprofen (Advil, Motrin)	<input type="checkbox"/> Bismuth subsalicylate (Pepto-Bismol)
<input type="checkbox"/> Cetirizine (Zyrtec)	<input type="checkbox"/> Hydrocortisone 1% cream
<input type="checkbox"/> Diphenhydramine (Benadryl)	<input type="checkbox"/> Topical antibiotic cream (Neosporin)
<input type="checkbox"/> Ricola Original cough drops	<input type="checkbox"/> Aloe
<input type="checkbox"/> Chloraseptic (Sore throat spray)	

**Parent/Guardian Authorization for Health Care:** This health history is correct, and the person described has permission to participate in all camp activities except as noted by me on this form and/or a physician. I attest that all immunizations required for school are up to date. I give permission to the medical personnel selected by Camp Blue Spruce to order X-rays, routine tests, and treatment; to release any records necessary for insurance purposes; and provide or arrange necessary related transportation for myself/my child. If I cannot be reached in an emergency, I give permission to the physician to secure and administer treatment, including hospitalization, for my child. This completed form may be photocopied. I understand that information about my child's health may be shared on a "need to know" basis with other Camp staff.

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\*\*Signature of First Parent or Guardian Date

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\*\*Signature of Second Parent or Guardian Date

I understand and agree to abide with any health related restrictions placed on my camp activities.

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Signature of minor participant Date

**\*\*Electronic Signatures:** I understand that typing my name above constitutes a legal signature confirming I acknowledge and agree to the terms of this release, waiver, indemnity agreement, and medical instructions.

First legal parent or guardian initials Second legal parent or guardian initials



# CAMP TAPAWINGO PARTICIPANT RELEASE, WAIVER AND INDEMNITY AGREEMENT

Participant Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Parent or Guardian Name (if Participant is under 18): \_\_\_\_\_

Parent/Guardian Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

*Please read this document carefully. It must be signed by all Participants attending or participating in programs and activities at Camp Tapawingo, or by at least one parent or guardian of all Participants who are under the age of 18 as of the date of attendance at the camp.*

It is acknowledged that attendance at and participation in camp activities at Camp Tapawingo exposes participants to certain risks that cannot in all cases be reasonably anticipated or avoided, including risk of property damage, illness, bodily injury and death. In consideration of Participant's attendance and participation in such activities, and the use of any facility or equipment of Camp Tapawingo, and engagement in and/or receipt of instruction in any activity or activity incidental thereto, the undersigned hereby (1) expressly assumes all such risks, known and unknown and inherent or not; and (2) voluntarily and absolutely releases, discharges, waives and relinquishes any and all claims, liabilities, demands, damages or actions, of any form or nature, for property damage, bodily injury and death, arising from or in any way relating to Participant's attendance at and participation in activities at Camp Tapawingo, including, but not limited to the use of any facility or equipment of Camp Tapawingo, and engagement in and/or receipt of instruction in any activity or activity incidental thereto.

The foregoing release, waiver and discharge of claims shall be extend and be effective as to Camp Tapawingo, Inc., an Oregon nonprofit corporation, North American Baptist Northwest, Inc., an Oregon nonprofit corporation, and their respective directors, officers, employees and agents, to the fullest extent permitted by Oregon law.

The undersigned further agrees to defend, indemnify and hold harmless Camp Tapawingo, Inc., an Oregon nonprofit corporation, North American Baptist Northwest, Inc., an Oregon nonprofit corporation, and their respective directors, officers, employees and agents from and against any and all claims, liabilities, demands damages or actions, of any form or nature, for property damage, bodily injury and death, that may be brought, made or asserted by any other person or entity arising from or in any way relating to Participant's attendance at and participation in activities at Camp Tapawingo, including but not limited to the use of any facility or equipment of camp Tapawingo, and engagement in and/or receipt of instruction in any activity or activity incidental thereto.

This agreement is entered into voluntarily and after careful consideration of its terms, and shall be binding upon the Participant and the undersigned Parent/Guardian, if signed by a Parent/Guardian, and their respective heirs, successors, personal representatives and assigns.

**Electronic Signature\*** of (indicate one) ☐ Participant or ☐ Parent/Guardian

X \_\_\_\_\_ Date: \_\_\_\_\_  
\* Please type your first and last name

☐ I understand that typing my name above constitutes a legal signature confirming I acknowledge and agree to the terms of this release, waiver and indemnity agreement.