



Great Basin Naturalists

2010 Summer Camp

Health and Safety Forms



Please return this form to: 16750 Mt. Rose Hwy, Reno, NV 89511

To Parent(s)/Guardian(s): Please complete the following BLUE and YELLOW forms and make a copy for your personal records. Send the original, signed forms to 16750 Mt. Rose Highway by June 1st, 2010. The YELLOW form must be completed by your child's physician.

Camper Name _____ Name Called _____

Address _____

City _____ State _____ Zip Code _____

Phone () _____ Parent's e-mail address _____

2009-2010 grade _____ School _____

Age on arrival to camp _____ Birthday (mo/day/year) _____

Special instructions: _____

Parent/Guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Home Phone () _____

Relationship to Camper: _____ Cell Phone () _____

E-mail: _____ Work Phone () _____

Second Parent/Guardian or other emergency contact:

Name: _____ Home Phone () _____

Relationship to Camper: _____ Cell Phone () _____

E-mail: _____ Work Phone () _____

Additional Parent/Guardian or other emergency contact:

Name: _____ Home Phone () _____

Relationship to Camper: _____ Cell Phone () _____

E-mail: _____ Work Phone () _____

Camper Name: _____
Birth Date: _____

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below:

Has/does the camper:

- | | | | |
|---------------------------------------|----------------|-----------------------------------|----------------|
| 1. Ever been hospitalized? | [] Yes [] No | 11. Had fainting or dizziness? | [] Yes [] No |
| 2. Ever had surgery? | [] Yes [] No | 12. Chest pain during exercise? | [] Yes [] No |
| 3. Have recurrent/chronic illness? | [] Yes [] No | 13. Had mononucleosis? | [] Yes [] No |
| 4. Had a recent infectious disease? | [] Yes [] No | 14. Ever had back/joint problems? | [] Yes [] No |
| 5. Had a recent injury? | [] Yes [] No | 15. Have and skin problems? | [] Yes [] No |
| 6. Have diabetes or similar disorder? | [] Yes [] No | | |
| 7. Have asthma? | [] Yes [] No | | |
| 8. Had seizures? | [] Yes [] No | | |
| 9. Have frequent headaches? | [] Yes [] No | | |
| 10. Wear corrective eyewear? | [] Yes [] No | | |

Please explain "Yes" answers in the space below, noting the number of the questions.

Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) attention deficit/hyperactivity disorder? [] Yes [] No
2. Ever been treated for emotional, behavioral, or eating disorders? [] Yes [] No
3. Had a significant life event that continues to affect the campers life? [] Yes [] No
(examples: history of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster)

Please Explain "Yes" answers in the space below. Know that we welcome all campers, regardless of learning disabilities.

Health Care Providers

Name of camper's primary doctor(s): _____ **Phone:** () _____

Name of dentist(s): _____ **Phone:** () _____

Name of orthodontist(s): _____ **Phone:** () _____

Additional Information: Please use the space below to provide any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. Attach additional information on a separate sheet of paper as needed:

CAMP PROGRAM

Campers may participate in the following activities:

Arts and Crafts, Ropes Course, Hiking, Outdoor Living Skills, Service-Learning, Swimming, Fishing, Bicycling, Outdoor Recreation Games, Reading, Camp Fire Cooking, Nature Photography, Wild Animal Viewing, Trail Maintenance, Environmental Science Lessons, and Team Building Activities. Please identify and describe any physical limitations and/or restrictions that may affect your child's ability to participate in any of these camp programs, and describe any specific equipment, accommodations, facilities and/or staff that would be required to facilitate their participation, safety, and wellbeing, so that the Director can determine whether the Camp can reasonably provide for their particular needs with its existing resources. Please use a separate sheet if necessary: _____

Can your child swim? _____ Is there any activity they are NOT to participate in? _____

- Allergies**
- No known allergies
 - Allergic to food
 - Allergic to medicine
 - Allergic to the environment (insect stings, hay fever, etc.)
 - Other

Please describe below what the camper is allergic to and the reaction seen:

-
- Diet/Nutrition**
- This camper eats a regular diet
 - This camper eats a regular vegetarian diet
 - This camper has special food needs (please describe below)

-
- Restrictions**
- I have reviewed the program and activities of camp and feel the camper can participate without restrictions.
 - I have reviewed the program and activities of camp and feel that the camper can participate with the following restrictions or adaptations.
(please describe below)

Medical Insurance Information

The camper is covered by family medical/hospital insurance Yes No
Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company _____ Policy Number _____

Subscriber _____ Insurance Company Phone Number () _____

Immunization Record: Provide the month and year for each immunization. Starred immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable. Please attach this form.

Medication This camper will not be taking any daily medications at camp
 This camper will be taking the following medication(s) while at camp:

| Name of Medication | Date Started | Reason for Taking it | When it is given | Amount or dose given | How it is given |
|--------------------|--------------|----------------------|------------------|----------------------|-----------------|
| | | | | | |
| | | | | | |
| | | | | | |

Parent/Guardian Authorization for Health Care

The health history provided is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian: _____ Date: _____ Relationship to Camper: _____