



PERSONAL INFORMATION

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age at Cheerio \_\_\_\_\_
Gender [ ] M [ ] F Parent/Guardian's Name \_\_\_\_\_ Home Telephone Number ( ) \_\_\_\_\_
Street Address (Not PO Box) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Mother's Work Phone ( ) \_\_\_\_\_ Mobile/Pager ( ) \_\_\_\_\_
Father's Work Phone ( ) \_\_\_\_\_ Mobile/Pager ( ) \_\_\_\_\_

IN CASE OF EMERGENCY AND PARENT IS NOT AVAILABLE CONTACT: (must be completed)

1. \_\_\_\_\_ Name Mobile Phone Day Phone Night Phone
2. \_\_\_\_\_ Name Mobile Phone Day Phone Night Phone
Camper's Physician \_\_\_\_\_ Phone ( ) \_\_\_\_\_
Camper's Dentist/Orthodontist \_\_\_\_\_ Phone ( ) \_\_\_\_\_
Health Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_
Company Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_
Name of Subscriber \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

TREATMENT/EMERGENCY CARE AUTHORIZATION

The above information is correct and complete to the best of my knowledge, and the Cheerio participant described has my permission to participate in all camp activities except as noted by me and/or the examining physician. I hereby give permission to the medical personnel selected by the camp director to provide and/or order medical treatment, x-rays and/or routine medical tests and to provide or arrange necessary related transportation for the participant named above. In the event I cannot be reached in an emergency, I hereby give permission to the camp director to secure, and to act as my agent in consenting to, medical and/or surgical treatment, including hospitalization, anesthesia or surgery, and to release to any physician and/or treatment facility or hospital relating to any pertinent insurance coverage, for the participant named above. This form may be photocopied.

Signature of Parent or Guardian Relationship Date

HEALTH HISTORY

Has the participant had or presently have (please check all that apply):

- [ ] Asthma\* [ ] Diabetes\* [ ] Headache/Head Injury [ ] Recent Illness/ Injury/ Hospitalization/ Surgery
[ ] Attention Deficit Disorder [ ] Ear Infections [ ] Joint Problems [ ] Seizures
[ ] Bed-wetting [ ] Emotional Disorder [ ] Menstrual Problems [ ] Sleep Walking
[ ] Blood Disorder [ ] Fainting/Dizzy Spells [ ] Orthodontic Appliance [ ] Other (please describe)
(anemia, mononucleosis, hepatitis, etc.)

\*Call camp office (336-869-0195) to request our asthma/diabetes information sheet so we may take better care of your child.

Please Explain Checked Items: \_\_\_\_\_

IMMUNIZATION HISTORY

Provide month and year. Starred (\*) items must be current.

DPT \_\_\_\_\_ Hepatitis B \_\_\_\_\_ \*Tetanus Booster (DT or T) \_\_\_\_\_ Haemophilus Influenza B (HIB) \_\_\_\_\_
\*Polio \_\_\_\_\_ Varicella (chicken pox) \_\_\_\_\_ \*MMR \_\_\_\_\_ TB \_\_\_\_\_

MEDICATIONS \* Please see the next page for medication restrictions

[ ] DOES NOT take medications on a regular basis. [ ] DOES take routine medication. (Please list below)

Table with 5 columns: Medication, Dosage, Time(s) Taken, Purpose of Medicine. Rows 1, 2, 3.

ALLERGIES

[ ] Food Allergy Yes [ ] No [ ] Allergic to: \_\_\_\_\_
Describe reaction if this food is eaten and what is done to manage it \_\_\_\_\_
[ ] Other Allergies (bees, latex, environmental substances, etc.) Yes [ ] No [ ] Allergic to: \_\_\_\_\_
[ ] Medication Allergy Yes [ ] No [ ] Allergic to: \_\_\_\_\_
Type of Reaction \_\_\_\_\_

CABIN

MI

First

Last

NAME

## PLEASE NOTE THE FOLLOWING MEDICATION RESTRICTIONS:

1. Prescription medications must be in **ORIGINAL PHARMACY CONTAINERS** and labeled with participants **FIRST AND LAST NAME** and with **MEDICATION NAME AND CORRECT DOSAGE INSTRUCTIONS. DOSAGE WILL NOT BE GIVEN CONTRARY TO WHAT IS WRITTEN WITHOUT A DOCTOR'S PRESCRIPTION.**
2. **Vitamins, herbals and over-the-counter medications** and other non-prescription drugs will **NOT** be accepted without a doctor's order or prescription. (The camp health center stocks benadryl, ibuprofen, tylenol, sudafed, robitussin, pepto-bismol, immodium, milk of magnesia and other common over-the-counter medicines.)
3. All such medications, vitamins, and over-the-counter preparations must be in **ORIGINAL PACKAGING** and **WITH CURRENT EXPIRATION DATES.**
4. Campers are **NOT** permitted to keep any type of medication, vitamins, herbal preparations, prescription creams and/or over-the-counter preparations with them in the cabins. (Exceptions are made on a case-by-case basis for inhalers for asthmatics.)
5. The cost of any prescription(s) filled for a camper during his/her camp stay will be borne by the parent(s). Every effort will be made to assist in achieving payment by the camper's insurance carrier. Payment for any out-of-pocket expense advanced by the camp is expected when the camper is picked up on the closing day of the camper's session.

## GENERAL HISTORY

Has had the following childhood illnesses [please indicate date(s)]:

Measles \_\_\_\_\_  Chicken pox \_\_\_\_\_  German Measles \_\_\_\_\_  Mumps \_\_\_\_\_

Participant's Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Participant's Dentist/Orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

If the participant receives care or takes medications for emotional, learning and/or psychological concerns, please provide background information so we might work effectively with him/her.

---

---

---

## DIET

Eats a regular diet  Vegetarian  Lactose intolerant

Other (please describe) \_\_\_\_\_

---

---

## ACTIVITY

No Restrictions

Restrictions (please describe) \_\_\_\_\_

---

---

---

MEDICAL EXAMINATION (Completed by Physician)

This information must be completed by a licensed physician or nurse practitioner based on a physical examination which must have been performed **WITHIN THE LAST YEAR.**

Date of physical examination \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Date this form is being completed \_\_\_\_\_ Blood Pressure \_\_\_\_\_

This person is under the care of a physician for the following: \_\_\_\_\_

The participant is currently receiving the following medical treatment for the above listed condition(s): \_\_\_\_\_

Treatment(s) to be continued while at Camp Cheerio: \_\_\_\_\_

Medication(s) to be administered at Camp Cheerio (include name, dosage & frequency): \_\_\_\_\_

Dietary Restrictions while at Camp Cheerio: \_\_\_\_\_

Known Allergies (to medications, food, latex or other substances) and type of reaction \_\_\_\_\_

Treatment for above-listed allergies: \_\_\_\_\_

Physical limitations or restrictions while at camp: \_\_\_\_\_

Additional health information needed for a good camp experience: \_\_\_\_\_

Signature of Physician/NP \_\_\_\_\_

Printed Name and Title: \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

