



# THE PHOEBE NEEDLES CENTER

# MEDICAL INFORMATION FORM

**CAMPER'S NAME** \_\_\_\_\_  
(first) (middle) (last) (preferred)

Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ Male \_\_\_\_\_ Female Social Security # \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Daytime Phone Number \_\_\_\_\_ Evening Phone Number \_\_\_\_\_

In case of emergency, contact \_\_\_\_\_ Relationship \_\_\_\_\_

Daytime Phone Number \_\_\_\_\_ Evening Phone Number \_\_\_\_\_

What is the current status of your youth's health? \_\_\_\_\_

Name of your physician or clinic \_\_\_\_\_ Phone number \_\_\_\_\_

Does the child attending camp have health insurance coverage? \_\_\_\_\_ yes \_\_\_\_\_ no

Name of company \_\_\_\_\_ Group/Individual Policy Number \_\_\_\_\_

Identification Number \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_

Is your youth allergic to bee or wasp stings? \_\_\_\_\_ yes \_\_\_\_\_ no If so, will they have medication? \_\_\_\_\_

List any activities from which your youth should be restricted \_\_\_\_\_

List any dietary restrictions \_\_\_\_\_

### **A NOTE TO PARENTS AND GUARDIANS**

In order to further provide for your youth's safety while at camp, we provide an accident and illness policy through the Church Insurance Agency. During the time your youth is attending camp at The Phoebe Needles Center, they will be provided with secondary insurance coverage for medical expenses due to accident or illness. This includes activities on and off the Phoebe Needles Center, Inc. property.

**FOR OFFICE USE ONLY** (please initial each item)

Check Medications \_\_\_\_\_ Check Allergies \_\_\_\_\_ Check Restrictions \_\_\_\_\_

## GENERAL HEALTH QUESTIONS

*Has/does the camper:*  
**(If yes, please explain on the back of page 3)**

- |   |     |    |
|---|-----|----|
| 1. Had a recent injury, illness, or infectious disease?                     | Yes | No |
| 2. Have a chronic or reoccurring disease?                                   | Yes | No |
| 3. Have frequent headaches?   | Yes | No |
| 4. Wear glasses, contacts, or protective eyewear?                           | Yes | No |
| 5. Have ear/sinus problems?   | Yes | No |
| 6. Ever had frequent infections?  | Yes | No |
| 7. Ever passed out during or after exercise?                                | Yes | No |
| 8. Ever been dizzy during or after exercise?                                | Yes | No |
| 9. Ever had seizures?   | Yes | No |
| 10. Ever had low or high blood pressure?                                    | Yes | No |
| 11. Ever been diagnosed with a heart murmur?                                | Yes | No |
| 12. Ever have heart disease (CHF, CAD, MI)?                                 | Yes | No |
| 13. Have COPD?  | Yes | No |
| 14. Ever have a Stroke/TIA?   | Yes | No |
| 15. Ever had back problems?   | Yes | No |
| 16. Ever have joint problems (knees, ankles)?                               | Yes | No |
| 17. Require an orthodontic appliance?                                       | Yes | No |
| 18. Have skin problems (rash, acne, itching)?                               | Yes | No |
| 19. Have diabetes?  | Yes | No |
| 20. Have asthma?  | Yes | No |
| 21. Have constipation or diarrhea?  | Yes | No |
| 22. Sleepwalk?  | Yes | No |
| 23. Sleep disorders? (including bedwetting)                                 | Yes | No |
| 24. Have an abnormal menstrual history?                                     | Yes | No |
| 25. Have an eating disorder?  | Yes | No |
| 26. GI problems (Abdominal, digestive)?                                     | Yes | No |
| 27. Have emotional/behavioral difficulties that required professional help? | Yes | No |
| 28. Have ADD or ADHD?   | Yes | No |
| 29. Use any type of tobacco products?                                       | Yes | No |
| 30. Had any recent surgery (last year)?                                     | Yes | No |

## ALLERGIES

**List any known allergies, or state "none" to:**

**MEDICATIONS:** \_\_\_\_\_

Reactions: \_\_\_\_\_

Treatment: \_\_\_\_\_

**FOODS:** \_\_\_\_\_

Reactions: \_\_\_\_\_

Treatment: \_\_\_\_\_

**PLANTS, ANIMALS, ETC.:** \_\_\_\_\_

Reactions: \_\_\_\_\_

Treatment: \_\_\_\_\_

**OTHER:** \_\_\_\_\_

Reactions: \_\_\_\_\_

Treatment: \_\_\_\_\_

## IMMUNIZATION HISTORY

Yes	No	VACCINE	Month/Year	Yes	No	VACCINE	Month/Year
<input type="checkbox"/>	<input type="checkbox"/>	DPT	_____	<input type="checkbox"/>	<input type="checkbox"/>	Influenza	_____
<input type="checkbox"/>	<input type="checkbox"/>	Tetanus/diphtheria	_____	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	_____
<input type="checkbox"/>	<input type="checkbox"/>	Polio	_____	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	_____
<input type="checkbox"/>	<input type="checkbox"/>	MMR	_____	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	_____
<input type="checkbox"/>	<input type="checkbox"/>	Measles	_____	<input type="checkbox"/>	<input type="checkbox"/>	Meningitis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mumps	_____	<input type="checkbox"/>	<input type="checkbox"/>	H1N1	_____
<input type="checkbox"/>	<input type="checkbox"/>	Rubella	_____	<input type="checkbox"/>	<input type="checkbox"/>	Other	_____

## MEDICATIONS

**All medication must be keep in the original container/packing identifying physician (if prescription), name of medication, dosage and frequency of administration. Bring enough medication to last the entire time at camp. Attach additional pages if needed to list all medications.**

MEDICATION

Dosage: \_\_\_\_\_

Frequency: \_\_\_\_\_

Reason for Taking: \_\_\_\_\_

MEDICATION

Dosage: \_\_\_\_\_

Frequency: \_\_\_\_\_

Reason for Taking: \_\_\_\_\_

MEDICATION

Dosage: \_\_\_\_\_

Frequency: \_\_\_\_\_

Reason for Taking: \_\_\_\_\_

MEDICATION

Dosage: \_\_\_\_\_

Frequency: \_\_\_\_\_

Reason for Taking: \_\_\_\_\_

### PARENT'S AUTHORIZATION FOR MEDICAL TREATMENT

The information on this form is correct and complete so far as I know, and the person herein described has permission to engage in all prescribed Summer Camp 2012 @ Phoebe Needles activities, except as noted by me.

I understand that there is a certain degree of risk and possible injury by reason of the program and its activities. I hereby give my permission to the staff of the Phoebe Needles Center, Inc. to provide routine health care, administer prescribed medications and seek emergency medical treatment, including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give my permission to the Phoebe Needles Center, Inc. to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give my permission to the physician selected by the Phoebe Needles Center, Inc. to secure and administer treatment, including hospitalization, for the above named person. This completed form may be photocopied for trips off the Phoebe Needles Center, Inc. property.

Parent/Guardian Signature \_\_\_\_\_

Print Name \_\_\_\_\_

Relationship \_\_\_\_\_

Date \_\_\_\_\_

### USE OF OVER-THE-COUNTER MEDICATIONS

**Circle "yes" or "no" to all the over-the-counter medications your camper may or may not receive if needed during camp at the Phoebe Needles Center.**

Acetaminophen or Tylenol (pain)	Yes	No
Pepto Bismol or generic (upset stomach)	Yes	No
Cough Suppressant plain (cough)	Yes	No
Benedryl pills or generic (itching or rash)	Yes	No
Ibuprofen or Advil (inflammation)	Yes	No
Cough drops/throat lozenges	Yes	No
Effervescent Pain Reliever	Yes	No
Antacid Tablets	Yes	No
Anti-diarrheal (diarrhea)	Yes	No
Calamine Lotion or Cortaid (itching or rash)	Yes	No
Hydrocortisone 1% Cream (itching)	Yes	No

### PLEASE RETURN ALL MATERIALS TO:

**The Phoebe Needles Center, Inc.**  
**732 Turners Creek Road**  
**Callaway, Virginia 24067-5814**  
**(540) 483-1518 (800) 848-1677**  
**Fax (540) 483-2235 Email PNCenter@gmail.com**  
**Additional forms available at [www.PhoebeNeedles.org](http://www.PhoebeNeedles.org)**