PHOEBE NEEDLES CENTER, INC.

DAY CAMP MEDICAL INFORMATION FORM

CAMPER'S NAME _____
(first) (middle) (last) (preferred)

Date of Birth _____ Gender _____

Parent/Guardian's Name _____

Address _____

City, State, Zip Code _____

Primary Phone Number _____ Secondary Phone Number _____

In case of emergency, contact _____ Relationship _____

Primary Phone Number _____ Secondary 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 _____

_____

COVID-19 VIRUS GUIDELINES

The American Academy of Pediatrics (AAP) has recommended that everyone over 16 years of age should receive the COVID-19 vaccine. At this time, Phoebe Needles Center, Inc. **IS NOT** excluding campers or staff who have not received the COVID-19 vaccination as there are limitations related to age restrictions and access.

The policy of the PNCI and the recommendation of the AAP and the Centers for Disease Control (CDC) is that individuals wear a face covering, maintain 6 feet of physical distance, and wash hands frequently, even after being vaccinated. If your camper has received the vaccination for COVID-19, please attach a copy of your vaccination certificate. This policy is subject to change as updated information becomes available.

FOR OFFICE USE ONLY (to be completed by medical screener)

Check Medications ☐ *Check Allergies* ☐ *Check Restrictions* ☐ *COVID-19 Screening* ☐

CAMPER'S NAME _____

GENERAL HEALTH QUESTIONS

Has/does the camper:

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

(If yes, please explain on the back of page 3)

ALLERGIES

List any known allergies, or state "NONE" to:

MEDICATIONS: _____

_____

Reactions: _____

Treatment: _____

FOODS: _____

_____

Reactions: _____

Treatment: _____

PLANTS, ANIMALS, ETC.: _____

_____

Reactions: _____

Treatment: _____

OTHER: _____

_____

Reactions: _____

Treatment: _____

☐ Check this box to give Phoebe Needles Center, Inc. staff permission to apply sunscreen to your camper

Is there any other information you think we should know about your camper? _____

_____

IMMUNIZATION VERIFICATION

I, _____ , attest that, _____, has received
(custodial parent/legal guardian) (camper)

ALL immunizations required for public schools in Virginia, and that these immunizations are up to date as of June 1, 2021: Diphtheria, Tetanus, & Pertussis (DTaP, DTP, or Tdap); Haemophilus Influenzae Type b (Hib) Vaccine; Hepatitis B Vaccine; Human Papillomavirus Vaccine (HPV); Measles, Mumps, & Rubella (MMR) Vaccine; Pneumococcal (PCV) Vaccine; Polio Vaccine; Varicella (Chickenpox) Vaccine

The date of his/her most recent tetanus shot is _____ (month/year).

CAMPER'S NAME _____

MEDICATIONS

All medications (prescription and non-prescription) MUST BE BROUGHT TO CAMP in the original container/packing, identifying physician (if prescription), name of medication, dosage, and frequency of administration. Bring enough medication to last the entire week of camp. Attach additional pages if needed to list all medications. IF NO MEDICATIONS ARE BEING USED, STATE "NONE."

NAME OF MEDICATION _____

Dosage : _____

Frequency: _____

Reason for Taking: _____

_____

NAME OF MEDICATION _____

Dosage : _____

Frequency: _____

Reason for Taking: _____

_____

NAME OF MEDICATION _____

Dosage : _____

Frequency: _____

Reason for Taking: _____

_____

NAME OF 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 @ Phoebe Needles activities, except as noted by me.

I understand that there is a certain degree of risk and possible injury in regard to the nature of the program and its activities. I hereby give my permission to the staff of 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 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 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 Phoebe Needles Center, Inc. property.

During the time your youth is attending camp at Phoebe Needles Center, Inc., they will be provided with secondary insurance coverage for medical expenses due to accident or illness. This includes activities on and off Phoebe Needles Center, Inc. property.

Parent/Guardian Signature _____

Print Name _____

Relationship _____

_____

Date

USE OF OVER-THE-COUNTER MEDICATIONS

Circle "yes" or "no" to any over-the-counter medications your camper may or may not receive if needed while at camp at Phoebe Needles Center, Inc.

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
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:

Phoebe Needles Center, Inc.
732 Turners Creek Road
Callaway, Virginia 24067-5814
(540)-483-1518
Fax (540) 483-2235 | PNCenter@gmail.com
Additional forms available at www.PhoebeNeedles.org