



## 2022 Medical Form - Campus House

**We encourage you to complete this medical form online instead of on paper.** If you've shared your email address with us in the past, then you already have an online account. Simply go to [Impact2818.org/myaccount](https://impact2818.org/myaccount), enter your email address, and click 'Forgot Password.' Or call (888) 628-2818 for assistance.

If you need to complete the medical form on paper, make sure both sides of this form are completed and returned to the address above as soon as possible, and not later than two weeks prior to the start of the event. Any medical forms not returned by 2 weeks before the event begins must be completed online.

**Remember, upon registration you agreed to assess your child for symptoms of COVID-19 for the 14 day period before arrival at camp. For a list of symptoms, please visit [cdc.gov/covid-19](https://cdc.gov/covid-19).**

Camper's name: \_\_\_\_\_ Event start date: \_\_\_\_\_  
Preferred name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_  
Primary Care Physician: \_\_\_\_\_ PCP Phone #: (\_\_\_\_)\_\_\_\_-\_\_\_\_

**Parent/Guardian Contact Information:**

Parent name: \_\_\_\_\_ Phone # C H W (\_\_\_\_)\_\_\_\_-\_\_\_\_  
Alternate Emergency Contacts:  
Name: \_\_\_\_\_ Phone # C H W (\_\_\_\_)\_\_\_\_-\_\_\_\_  
Name: \_\_\_\_\_ Phone # C H W (\_\_\_\_)\_\_\_\_-\_\_\_\_

**Insurance Information:**

Is the camper covered by family medical/hospital insurance? Yes No  
Policy holder's name: \_\_\_\_\_ Employer's name: \_\_\_\_\_  
Relationship to camper: \_\_\_\_\_ Insurance provider: \_\_\_\_\_  
Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

**Allergies:**

Does this camper have any food allergies? Yes No  
If yes, type of food(s)? \_\_\_\_\_ Causes anaphylaxis? Yes No  
Please describe reaction and what is done to manage it? \_\_\_\_\_

\*Please note, our camp sites are NOT nut-free facilities. A doctor's note is required for all specialized diets. Parents can bring medically necessary supplemental meal items for their camper if arranged with the Camp Site Manager at least two weeks prior to arrival.

Does this camper have any medication allergies? Yes No  
If yes, type of medication(s)? \_\_\_\_\_ Causes anaphylaxis? Yes No  
Please describe reaction and what is done to manage it? \_\_\_\_\_

Does this camper have any other allergies (bee stings, etc.)? Yes No  
If yes, type of allergy? \_\_\_\_\_ Causes anaphylaxis? Yes No  
Please describe reaction and what is done to manage it? \_\_\_\_\_

Camper's name: \_\_\_\_\_ Event start date: \_\_\_\_\_

**Health Concerns:**

Please circle those that pertain to your camper.

- ADD/ADHD      Asthma      Autism Spectrum Disorder      Bedwetting      Bleeding/clotting disorder  
 Diabetes\*      Epilepsy      Fainting      Frequent ear infections      Headaches      Seizure disorder  
 Severe menstrual cramps      Sleepwalking      Surgical history      Other

Describe those circled above and how to best manage ongoing concerns (\*for diabetes, give a brief description of daily care needs and a range for the camper's normal blood sugar levels): \_\_\_\_\_

---



---



---

(For female campers) Has this camper menstruated?    Yes    No  
 If not, has she been told about menstruation?    Yes    No

Will this camper have any medications (prescription or over-the-counter)?    Yes    No  
 If yes, please list all medications below. Attach an additional page if necessary. All medication must be in its original container, labeled with the camper's name, and given to the medic at check-in. **\*\*\*Please note herbal remedies, vitamins, and oils cannot be administered by the camp or counselors without a doctor's note. No medication will be given in conflict with its label without a doctor's note.\*\*\***

Name of Medication	Dosage	Time to be Administered	Special Instructions
ex 1: Clarinex tablet ex 2: Zyrtec syrup	5mg 1 teaspoon	Breakfast As needed	

Please list any standard, over-the-counter medication your camper should NOT receive (ex. Tylenol, Advil, Imodium, etc.): \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

In order to set our counselors and your camper up for success, we ask to be informed of any special physical, mental, or emotional concerns relevant to your child. We use this information to provide staffing levels and to ensure that, when we are able, accommodations are available. Please note if your child has an IEP at their school, or has any disabilities, impairments, or other medical information that will help us best serve your camper: \_\_\_\_\_

---



---