IMPACT 2818: Outdoor Ministries
of the United Methodist Churches of Indiana

2022 Medical Form

Camp Rivervale
496 Rivervale Road
Mitchell, IN 47446
Phone: (812) 849-6824
Fax: (317) 735-9884
Email: rv@impact2818.org

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**, 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.

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? ____________________________________

Continued on back...

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): ________________

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(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: ____

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