



# COMING TO CAMP

Health Information • Physical Exam • Behavior and Health Acknowledgement

Please complete this form one month before arriving and send it to:  
**Camp Kanuga**

PO Box 250, Hendersonville, NC 28793  
**TEL:** 828-692-9136 **FAX:** 828-696-3589

## PARTICIPANT INFORMATION

Session(s) attending \_\_\_\_\_

Participant Name \_\_\_\_\_

Male  Female  Birth date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Social Security Number \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Parent/Legal Guardian Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Tel # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

2nd Parent/Legal Guardian Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Tel # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

## INSURANCE INFORMATION

**A copy of your insurance card (front & back) should accompany this form when returned to Camp Kanuga.** If you do not have medical insurance, Kanuga holds a policy for uninsured participants.

Insurance Company \_\_\_\_\_ Name on card \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Phone # or address where claims should be made \_\_\_\_\_

Employer name & address \_\_\_\_\_

Area hospitals have requested the following information from the insured parent/legal guardian to expedite claims:

Social Security Number \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Birth date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

## HEALTH HISTORY

Does the participant have a history of:

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
ADD or ADHD?	<input type="checkbox"/>	<input type="checkbox"/>	Ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Asthma?	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorders?	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual abnormalities?	<input type="checkbox"/>	<input type="checkbox"/>
Bedwetting?	<input type="checkbox"/>	<input type="checkbox"/>	Emotional problems?	<input type="checkbox"/>	<input type="checkbox"/>	Seizures?	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral problems?	<input type="checkbox"/>	<input type="checkbox"/>	Glasses or contacts?	<input type="checkbox"/>	<input type="checkbox"/>	Stomach problems?	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac problems?	<input type="checkbox"/>	<input type="checkbox"/>	Headaches?	<input type="checkbox"/>	<input type="checkbox"/>	Surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmurs?	<input type="checkbox"/>	<input type="checkbox"/>	Urinary problems?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered yes to any of the above questions, please give details and special instructions \_\_\_\_\_

\_\_\_\_\_

Please also describe any medical treatments the participant has had in the past. \_\_\_\_\_

\_\_\_\_\_

# CURRENT HEALTH

<b>Is the participant</b>	<u>Yes</u>	<u>No</u>	
allergic to poison ivy?	<input type="checkbox"/>	<input type="checkbox"/>	
allergic to bee stings?	<input type="checkbox"/>	<input type="checkbox"/>	Does the participant normally carry an Epi-pen? _____
allergic to foods?	<input type="checkbox"/>	<input type="checkbox"/>	What kinds of food? _____
allergic to medications?	<input type="checkbox"/>	<input type="checkbox"/>	Which medications? _____
allergic to anything else?	<input type="checkbox"/>	<input type="checkbox"/>	What? _____

If you answered yes to any of the questions above, describe specifically the reaction and the best method of treatment. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Describe any dietary restrictions or considerations. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Describe any physical/mental/psychological/emotional conditions that may impact camp participation. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

# IMMUNIZATIONS

	Date of 1st dose	Date of 2nd dose or booster	Date of 3rd dose or booster	Date of 4th dose or booster
DTP				
TD & Booster				
Polio				
Hepatitis B				
MMR				
Varicella (chicken pox)				
H1N1 (swine flu)				
Hib				

# HOME HEALTH CARE

Name of family doctor \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Tel # \_\_\_\_\_

Name of dentist \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Tel # \_\_\_\_\_

Name of orthodontist \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Tel # \_\_\_\_\_

# PHYSICAL EXAMINATION

To be completed by licensed medical personnel within the **12 months** preceding camp.

Name of examiner \_\_\_\_\_ Date of Exam \_\_\_\_\_

Name of person being examined \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_

Camp Kanuga's programs involve challenging and sometimes strenuous activities such as swimming, canoeing, rock climbing, ropes courses, competitive sports, backpacking, hiking, and for campers ages 13+, whitewater rafting.

Are there any physical conditions requiring restrictions on participation in the above mentioned programs?  Yes  No

Description of specific restrictions and instructions while at camp: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any current or ongoing treatments? Yes  No

Description of treatments and instructions while at camp: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all medications (OTC and prescribed) the participant will be taking while at camp and medications taken in the last year.

Medication 1: \_\_\_\_\_ Dose? \_\_\_\_\_ When? \_\_\_\_\_ Taking during camp?  
For what reason: \_\_\_\_\_  Yes  No

Medication 2: \_\_\_\_\_ Dose? \_\_\_\_\_ When? \_\_\_\_\_  Yes  No  
For what reason: \_\_\_\_\_

Medication 3: \_\_\_\_\_ Dose? \_\_\_\_\_ When? \_\_\_\_\_  Yes  No  
For what reason: \_\_\_\_\_

Medication 4: \_\_\_\_\_ Dose? \_\_\_\_\_ When? \_\_\_\_\_  Yes  No  
For what reason: \_\_\_\_\_

Any additional information about the participant that the health care staff of Camp Kanuga should be aware of? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have examined and reviewed the health history of the participant. It is my opinion that the participant is physically able to be involved in activities provided by Camp Kanuga, except as noted above.

Signature of licensed medical personnel \_\_\_\_\_ Date \_\_\_\_\_

**Contact information**

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Work # \_\_\_\_\_

# PARENT/LEGAL GUARDIAN AGREEMENT\*

## Camper Health

I acknowledge that all of the information provided on the participant's health form is correct and complete as far as I know. I hereby give permission to the medical personnel selected by Kanuga Conferences Inc. to provide routine healthcare; dispense medications; order X-rays, routine tests or treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me or my child. In the event of an emergency and an effort to reach me fails, I hereby give permission to the physician selected to secure and administer treatment, including hospitalization, for the participant named above.

Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

\*If you cannot sign this agreement for religious or other reasons, please contact the camp. A modified version is available if you do not want your child to receive over-the-counter medications.

## Camper Behavior

I am aware and understand that Camp Kanuga, through its directors and the president of Kanuga, reserves the right to terminate participation at the camp and to send home at his/her expense any person whose conduct is considered detrimental to the camp community or to Camp Kanuga. I agree to pick up my child from camp or to make the necessary travel arrangements if the camp director decides that my child's behavior warrants removal from the camp community.

Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# CAMPER COVENANT

The camp community is based on mutual trust and respect for others. Because of this, certain behaviors and activities are not allowed at camp and may result in dismissal from camp including the use or possession of cell phones, weapons, fireworks, tobacco, alcohol or illegal drugs. Also, altering ones appearance in any permanent or semi-permanent way, threats of violence, fighting or engaging in inappropriate physical relationships with other community members may result in dismissal from camp. Attending Camp Kanuga is a privilege and campers are encouraged to enter fully and cooperatively into the camp community. I accept my role as a community member and understand that participating in any of the damaging behaviors and activities described above may result in my dismissal from Camp Kanuga. I also accept any limits on my participation as described in the health sections of this coming to camp packet.

Camper Signature \_\_\_\_\_

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Section below to be completed by camp staff member

## HEALTH SCREENING

	Medications at camp	Dose	When	Used for
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Lice Check:  Yes  No Follow up needed? \_\_\_\_\_

Observable signs of injury or illness:  Yes  No What? \_\_\_\_\_

Recent illnesses/exposure to communicable disease \_\_\_\_\_

Changes to health form/Special instructions from parents \_\_\_\_\_

Health form reviewed by \_\_\_\_\_ Date \_\_\_\_\_ Screening provided by \_\_\_\_\_ Date \_\_\_\_\_