CAMP DAWO Medical History Form

Full name: _____ **DOB:** _____

Informed Consent and Authorization

By completing this form, I understand that participation in Camp Dawo activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the camp director. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

In case of an emergency involving me or my child, I understand that efforts will be made to contact the individual listed as the emergency contact person by the medical provider and/or adult leader. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health-care provider involved in providing medical care to the participant. Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, includes examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

I have carefully considered the risk involved and hereby give my informed consent for my child to participate in all activities offered at Camp Dawo. I further authorize the sharing of the information on this form with or professionals who need to know of medical conditions that may require special consideration in conducting camp activities.

With appreciation of the dangers and risks associated with programs and activities, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against Camp Dawo, Camp Dawo /Dawo Trails counselors and coordinators, and all employees, volunteers, related parties, or other organizations associated with any program or activity. I also hereby assign and grant to Camp Dawo, Camp Dawo employees, as well as their authorized representatives, the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child at all camp activities, and I hereby release the Camp Dawo, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all liability from such use and publication. I further authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said photographs/film/videotapes/electronic representations and/or sound recordings without limitation at the discretion of Camp Dawo, and I specifically waive any right to any compensation.

I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity. If I am participating at If the participant is under the age of 18, a parent or guardian's signature is required.

Participant's signature:_____ Date: _____

Parent/guardian signature for youth:_____ Date: _____

(If participant is under the age of 18)

Second parent/guardian signature for youth:_____ Date: _____

(If required; for example, California)

General Information/Health History

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Full name: _____ **DOB:** _____

Address: _____

City: _____ State: _____ ZIP code: _____

Age: _____ Gender: _____ Mobile phone: _____ Telephone: _____

Travel Insurance Company (name and number): _____

Policy No.:

Health and Accident Insurance Company(name and number): _____

Policy No.:

Please attach a photocopy of both sides of the insurance card. If you do not have medical/travel insurance, enter "none" above.

In case of emergency notify the person below:

Name: _____ Relationship: _____

Address: _____ Home phone: Other phone: _____

Alternate contact name: _____ Alternate's phone: _____

Health History

Do you currently have or have you ever been treated for any of the following? **List participant restrictions, if any:** _____ **None:** ☐

Yes	No	Condition	Explain
☐	☐	Diabetes	**Last HbA1c percentage and date**:
☐	☐	Hypertension (high blood pressure)	
☐	☐	Adult or congenital heart disease/heart attack/chest pain (angina)/heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers.	
☐	☐	Family history of heart disease or any sudden heart-related death of a family member before age 50.	
☐	☐	Stroke/TIA	
☐	☐	Asthma	**Last attack date**:
☐	☐	Lung/respiratory disease	
☐	☐	COPD	
☐	☐	Ear/eyes/nose/sinus problems	
☐	☐	Muscular/skeletal condition/muscle or bone issues	
☐	☐	Head injury/concussion	
☐	☐	Altitude sickness	
☐	☐	Psychiatric/psychological or emotional difficulties	
☐	☐	Behavioral/neurological disorders	
☐	☐	Blood disorders/sickle cell disease	
☐	☐	Fainting spells and dizziness	
☐	☐	Kidney disease	
☐	☐	Seizures	**Last seizure date**:
☐	☐	Abdominal/stomach/digestive problems	
☐	☐	Thyroid disease	
☐	☐	Excessive fatigue	
☐	☐	Obstructive sleep apnea/sleep disorders	**CPAP: Yes**: ☐ No: ☐
☐	☐	List all surgeries and hospitalizations	**Last surgery date**:
☐	☐	List any other medical conditions not covered above	

General Information/Health History Continued

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Full name: _____ **DOB:** _____

Allergies/Medications

Are you allergic to or do you have any adverse reaction to any of the following?

Yes	No	Allergies or Reactions	Explain	Yes	No	Allergies or Reactions	Explain
☐	☐	Medication		☐	☐	Plants	
☐	☐	Food		☐	☐	Insect bites/stings	

List all medications currently used, including any over-the-counter medications. If additional space is needed please attach

☐ **CHECK HERE IF NO MEDICATIONS ARE ROUTINELY TAKEN.** ☐ **MEDICATIONS TAKEN INDEPENDENTLY**

Medication	Dose	Frequency	Reason

☐ **YES** ☐ **NO** **Non-prescription medication administration is authorized with these exceptions:** _____

Administration of the above medications is approved for youth by:

_____ / _____

Parent/guardian signature **MD/DO, NP, or PA signature (if your state requires signature)**

Bring enough medications in sufficient quantities and in the original containers. Make sure that they are NOT expired. You SHOULD NOT STOP taking any maintenance medication unless instructed to do so by your doctor. Anti-malarial medication is required for camp participation and may be prescribed as well as other vaccines needed for travel. Please follow the advisement of the travel clinic or prescribing provider.

Immunizations

The following immunizations are recommended by the Camp Dawo. **Yellow Fever vaccine is required for travel/camp attendance.** If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received. Can attach copy of yellow card and school vaccination record.

Yes	No	Had disease	Immunization	Dates
☐	☐	☐	Tetanus	
☐	☐	☐	Pertussis	
☐	☐	☐	Diphtheria	
☐	☐	☐	Measles/Mumps/Rubella (MMR)	
☐	☐	☐	Polio	
☐	☐	☐	Varicella (chicken Pox)	
☐	☐	☐	Hepatitis A	
☐	☐	☐	Hepatitis B	
☐	☐	☐	Meningitis	
☐	☐	☐	Influenza	
☐	☐	☐	Yellow Fever	
☐	☐	☐	Other:	
☐	☐	☐		

Please list any additional information about your medical history:

DO NOT WRITE IN THIS BOX Camp Dawo Staff ONLY

Reviewed by _____

Date: _____

Further approval required: ☐ Yes ☐ No

Reason: _____

Approved by: _____

Date: _____

Medical Physical

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This part must be completed by certified and licensed physicians (MD, DO), nurse practitioners, or physician assistants.

Full name:_____ **DOB:**_____

You are being asked to certify that this individual has no contraindication for participation in a International Camp experience.

Examiner: Please fill in the following information:

	Yes	No	Explain
Medical restrictions to participate	☐	☐	

Yes	No	Allergies or Reactions	Explain	Yes	No	Allergies or Reactions	Explain
☐	☐	Medication		☐	☐	Plants	
☐	☐	Food		☐	☐	Insect bites/stings	

Height (inches):_____ **W eight (lbs.):**_____ **B MI:**_____ **B lood Pressure:**_____/_____ **P ulse:**_____

	Normal	Abnormal	Explain Abnormalities
Eyes	☐	☐	
Ears/nose/ throat	☐	☐	
Lungs	☐	☐	
Heart	☐	☐	
Abdomen	☐	☐	
Genitalia/hernia	☐	☐	
Musculoskeletal	☐	☐	
Neurological	☐	☐	
Other	☐	☐	

Examiner's Certification

I certify that I have reviewed the health history and examined this person and find no contraindications for participation in a International camp experience OR This participant can participate (with noted restrictions):

True	False	Explain
☐	☐	This patient is safe to travel to an international camp.
☐	☐	Does not have uncontrolled heart disease, asthma, or hypertension.
☐	☐	Has not had an orthopedic injury, musculoskeletal problems, or orthopedic surgery in the last six months or possesses a letter of clearance from his or her orthopedic surgeon or treating physician.
☐	☐	Has no uncontrolled psychiatric disorders.
☐	☐	Has had no seizures in the last year.
☐	☐	Does not have poorly controlled diabetes.
☐	☐	Has or understands the need for international travel vaccinations prior to departure
☐	☐	Other info:

Examiner's Signature:_____ **Date:** _____

Provider printed name: _____

Address: _____

City:_____ State:_____ ZIP code: _____

Office phone: _____