High Adventure Health Form

Return this form to: **Sonlight Christian Camp**
PO Box 536
Pagosa Springs, CO 81147

Camp Dates: ___________________________________

Name of the camp week:_________________________
(for example Wilderness Week for girls/boys, Adult women's backpack trip, the Bike Trip, Faith Presbyterian backpack trip, First Presbyterian Fayetteville, Covenant Presbyterian — and so forth)

Name:_____________________________________
Last First MI

Gender:_________ Age:________ Birth date:__________

Custodial Parent: ______________________________

Address:____
Street or PO Box

____
City State Zip

Cell Phone: (_____)___________________________
Home telephone: (____)_______________________________

CONTACT INFORMATION:

Please complete ALL information– it is required by our state regulations for adults and minors

Sonlight does use cell phones on backpack trips, but service is not consistently available in our wilderness. We will call the parent/guardian identified below, if your child is evacuated. We do not routinely call parents/guardians for health concerns managed in the field by Sonlight Camp guides. In an emergency, should the parent/guardian not be available by phone we will call the alternate contacts. Emergency care will not be withheld in the event the parent/guardian or alternate is not available by phone. Provide contact information for two alternates who know your child should we be unable to reach you. Adult participants, please list 3 people we should contact in case of emergency and complete all contact information for each individual.

Parent/Guardian/Spouse Name: ________________________________ Work Phone: (____) _________________ Home Phone: (_____)____________

Address:____ Cell Phone: (____) ___________
Street City State Zip

Alternate contact #1: ____ Relationship to camper:______________________________________

Work Phone (____) ___________________________ Home Phone (____)______________________________

Address____ Cell Phone: (____)____________
Street City State Zip

Alternate contact #2: ____ Relationship to camper:______________________________________

Work Phone (____) ___________________________ Home Phone (____)_____________________________

Address ____ Cell Phone: (____)____________
Street **City** **State** **Zip**

HEALTH HISTORY: ***To be completed and signed by parent/guardian, or adult trip participant***

Keep a copy of this form for your records, and record changes in you/your child's health status. Notify Sonlight in writing of changes.

Diet:

☐ Does not eat red meat ☐ Does not eat pork ☐ Does not eat eggs

☐ Does not eat poultry ☐ Does not eat seafood ☐ Does not eat dairy products

☐ Other *(describe)*

If any of the boxes above are checked, please clarify below if this is a diet preference, an intolerance or allergy.

____

____

Allergies: Check those which apply to this camper.

☐ This camper has **no known allergies**

☐ This camper is allergic to the following medication: ______________________________ Describe reaction: _________________

☐ This camper is allergic to the following food(s): _________________________________ Describe reaction:_________________

☐ This camper is allergic to the following: ____ Describe reaction:_________________

Medications: Please list *All* medications (including over the counter or nonprescription medications) taken routinely. Bring enough medication to last the entire time at camp. **Medications must be in the original packaging/bottle** that identifies the prescribing physician (if a prescription drug) the name of the medication, dosage, the patient and the frequency of administration.

☐ This person takes ***NO*** medications on a regular basis.

☐ This person takes medications listed below, including over the counter medications:

Name of medication: ____ **Name of medication:**_________________________________

Reason for taking: ____ Reason for taking:_____________________________________

Dosage:____ Dosage:____

Specific times taken each day: ___________________________________ Specific times taken each day: __________________________

Date medication started: ____ Date medication started:______________________________

Most recent change in dosage (if any) ______________________________ Most recent change in dosage (if any):____________________

Chronic Concerns: Check all that pertain to this individual, and provide information about supportive healthcare.

☐ This individual has no chronic health concerns and is capable of full participation in camp program

☐ This individual has the following chronic health concerns:

☐ Asthma ☐ Headaches ☐ Sleepwalking ☐ Frequent ear infections

☐ Diabetes ☐ Bedwetting ☐ Menstrual cramps ☐ Frequent colds ☐ Seizures

☐ Other (please describe) ____

Provide information about supportive health care for each checked item: ____

____

Mental and Emotional Health: If this individual receives care or takes medication for emotional, learning and/or psychological concerns, provide background information to help us work effectively with this camper or adult:____________________

____

____

____

Immunization History: Enter the date each immunization was given.

Immunization					
DPT:Diptheria, Tetanus, Pertussis					
Td/DT: Tetanus Diptheria			Must be current within past 10 years		
MMR: Mumps, Measles, Rubella			Measles booster (prior to 7th grade)		
IVP/OPV: Polio					
HepB: Hepatitis B					
Hib: H, influenzae, type b					
Varicella: Chickenpox			History of disease. Yes_____ Year________ *(optional)*		

First Aid Kit Medications:

These medications are carried by Sonlight Camp guides to help manage common illness or injury. They are administered as directed by our medical protocols. **Cross out** those which the trip participant should not be given.

Acetamin ophen *(Tylenol)* Diphenhydramine *(Benadryl)* Ibupro phen *(Advil)* T ums antacid Double Antibiotic Cream Pseudoephedrine *(Sudafed)* Hydrocortisone Cream Lidocaine 2% Topical Epinepherine injection 1:1000

Acknowledgement Of Activities:

I/my child has signed up for a wilderness backpacking trip in the Rocky Mountains of Colorado. I acknowledge that the activities involved will include remote multi-day wilderness travel in a National Forest Service or Wilderness Area. The participant will be carrying a forty to fifty pound pack over terrain that may be rugged, rocky, steep, loose, slick, snowy or unpredictable. Travel may be up to ten miles a day. Nights will be spent camping and cooking in the wilderness. Weather and temperature can vary widely from warm /sunny to cold and snowy and everything in between. I acknowledge that if needed, advanced health care may be several days away. I understand that the trip will occur at high altitude, possibly topping out between 12,500 and 13,300 feet. I understand that high altitude may cause serious or fatal illness as well as exerting extra strain on the circulatory and respiratory systems.

Signature of Participant: ______________________________ Date: ____________

Signature of Parent/Guardian *(for those under 18 years of* age): ______________________________ Date: ____________

Authorization for Health Care:

The health history is correct, and the person described has permission to participate in all camp activities except as noted by me and/or the examining physician. I give permission for Sonlight Staff to administer first aid and/or transport as they see needed and to turn care and transport over to search and rescue personal if the need should arise. I give permission to the physician selected by Sonlight Camp to order X-rays, routine tests and treatment for the health of me/my child. If I cannot be reached in an emergency, I give permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for me/my child. Sonlight has permission to obtain a copy of my/my child's health record from the providers they access to treat my child. I understand that information about me/my child's health will be shared on a "need to know" basis with other Sonlight Camp staff, to include guide staff and/or food service staff. This form may be photocopied.

Signature of Parent/Guardian or Adult Participant: ______________________________ Date: ____________

Billing Information for Health Care:

Participants in ***Sonlight Summer Camps*** (programs sponsored by Sonlight) are covered by limited accident/sickness insurance provided by Sonlight Camp. (This is NOT a major medical policy). Campers and adults attending Sonlight Camp with a church or organization (i.e. rental groups) should check with their leader for details regarding accident/sickness insurance, if any, their organization provides.

Is this participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name: ____________________ Name of insured: ____________________

Relationship to insured: ______________________________

Social security number of policy holder or insurancde ID number: ______________________________

Date/Time Initial | **Sonlight Nursing Notes**

_______ **Entrance Screening** conducted according to Sonlight Camp protocols, and significant findings noted.

____

A. Signs/symptoms of illness/injury upon arrival?....................................... ☐ No ☐ Yes as noted below

B. History of exposure to communicable disease?..................................... ☐ No ☐ Yes as noted below

C. Additions or corrections to this health history?....................................... ☐ No ☐ Yes as noted below

D. Medications given to healthcare provider?... ☐ No ☐ Yes as noted below

____

____

Exit Note *Check one of the following*: **Date:** ____________

☐ Left camp this day with no reported illness/injury **Initial:** ____________

☐ Left camp this day with the following problem/concern ______________________________

This problem was referred to *(name of responsible party)* ______________________________

Medications returned to: ______________________________

Health Care Recommendations from a Licensed Physician or Nurse Practitioner:

To Physicians and Nurse Practitioners: This individual has enrolled in a summer camp program at Sonlight Camp, in southwest Colorado. The program is based at 8,000 feet above sea level. The program involves physical activity (backpacking, hiking and climbing peaks). Our healthcare staff will use your information to meet the health needs of the person described. Note that not all healthcare staff are registered nurses; some have only first aid skills. For further clarification of the camp program and activities, please feel free to call: 970/ 264-4379 or visit our website: www.sonlightcamp.org.

To be completed by a physician or nurse practitioner based on an examination done within 1 year of camp participation.

Date of examination _______________ BP _________________Weight ______________ Height _______________

This individual is under the care of a physician for the following: ____

____

Recommendations and Restrictions:

Physician order for medication (prescription and over the counter) and/or treatment to be administered at camp:

____

____

Description of prescribed meal plan or dietary restrictions:

____

____

Known allergies:

____

____

List activities in which this person should not participate, or have limited participation (describe limitation):

____

____

Additional information for health care staff at camp, to include significant medical history:

____

____

____

General History:

Circle the appropriate response for each statement

YES NO This individual has had chicken pox

YES NO This individual has had mononucleosis in the past 12 months

YES NO This individual has a history of illness, injury or surgery which will affect participation.

If “yes” explain:

____

Signature of Physician or Nurse Practitioner: ____

Printed Name: ____

Address, City, State and Zip____

Phone: (_____) ____ Date: ___________________