

High Adventure Health Form

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

Name: _____
Last First MI



Gender: _____ Age: _____ Birth date: _____

Return this form to Sonlight, or the individual handling registration for your camp **two weeks prior to arriving at camp.**

Custodial Parent: _____

Camp Dates: _____

Address: _____
Street or PO Box

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)

City State Zip

Home telephone: (_____) _____

CONTACT INFORMATION:

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

Sonlight does not use cell phones on backpack trips, as 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 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. Adults please list 3 people we should contact in case of emergency, and complete all contact information for each individual.

Parent/Guardian/Spouse Name: _____ Daytime telephone: (_____) _____ Evening telephone: (_____) _____

Address: _____ Cell Phone: (_____) _____
Street City State Zip

Alternate contact #1: _____ Relationship to camper: _____

Daytime Phone (_____) _____ Evening Phone (_____) _____

Address _____ Cell Phone: (_____) _____
Street City State Zip

Alternate contact #2: _____ Relationship to camper: _____

Daytime Phone (_____) _____ Evening 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, 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				
<i>DPT: Diphtheria, Tetanus, Pertussis</i>				
<i>Td/DT: Tetanus Diphtheria</i>			Must be current within past 10 years	
<i>MMR: Mumps, Measles, Rubella</i>			Measles booster (prior to 7th grade)	
<i>IVP/OPV: Polio</i>				
<i>HepB: Hepatitis B</i>				
<i>Hib: H, influenzae, type b</i>				
<i>Varicella: Chickenpox</i>			History of disease. Yes _____ Year _____ (optional)	

First Aid Kit Medications: These medications are carried by Sonlight 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.

- | | | | |
|----------------------------------|-------------------------------------|-----------------------------|----------------------|
| Acetaminophen (<i>Tylenol</i>) | Diphenhydramine (<i>Benadryl</i>) | Ibuprophen (<i>Advil</i>) | Tums antacid |
| Double Antibiotic Cream | Pseudoephedrine (<i>Sudafed</i>) | Hydrocortisone Cream | Lidocaine 2% Topical |
| Epinephrine 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 and 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, usually 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 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. (Not a major medical policy). Campers and adults attending Sonlight 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 insurance ID number: _____

Date/Time Initial	Sonlight Nursing Notes
_____	<p>Entrance Screening conducted according to Sonlight protocols, and significant findings noted.</p> <p>A. Signs/symptoms of illness/injury upon arrival?..... <input type="checkbox"/> No <input type="checkbox"/> Yes as noted below</p> <p>B. History of exposure to communicable disease?..... <input type="checkbox"/> No <input type="checkbox"/> Yes as noted below</p> <p>C. Additions or corrections to this health history?..... <input type="checkbox"/> No <input type="checkbox"/> Yes as noted below</p> <p>D. Medications given to healthcare provider?..... <input type="checkbox"/> No <input type="checkbox"/> Yes as noted below</p>

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 (climbing wall, mountain biking, archery, white water rafting, hiking). Our health care 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 _____

Phone: (_____) _____ Date: _____