Sonlight Health Form

Camper Name: ____

Last First Middle

Return this form by **May 15**

Male ☐ Female ☐ Age:_____________ Birth date:______________________________

Mail:
Sonlight Christian Camp
PO Box 536
Pagosa Springs, CO 81147

Fax: 877.335.2331

Email:
registrar@sonlightcamp.org

Camp Dates:_______________________

Name of the camp week:
____

For example Junior Camp, Adventure Discovery, High School 10 Day Camp, etc.

Contact Information: We will contact you any time out of camp health care is indicated, or we have a question about your child. Provide the following contact information for us to use during your child's camp week.

Camper lives with: ☐ Parent(s) (single household) ☐ Both Parents (separate households)

Other Relative: Relationship ____________________________________

Household A:____

Custodial Adult A: __________________________Custodial Adult B: ________________________

Relationship to Camper: _____________________Relationship to Camper:___________________

Preferred Phone:(____) _____________________ Preferred Phone:(____) ___________________

Alternate Phone: :(____) ____________________ Alternate Phone: :(____) __________________

Street Address:____

City, State, ZIP: ____

Household B :____

Custodial Adult A: __________________________Custodial Adult B: ________________________

Relationship to Camper: _____________________Relationship to Camper:___________________

Preferred Phone:(____) _____________________ Preferred Phone:(____) ___________________

Alternate Phone: :(____) ____________________ Alternate Phone: :(____) __________________

Street Address:____

City, State, ZIP: ____

There are times we communicate via email with parents about health concerns in our camp community. Please provide preferred email addresses for health related concerns:

Primary Guardian Email:______________________Secondary Guardian Email: __________________________________

Allergies: Check those which apply to this camper. ☐ This camper has **no known allergies**

☐ This camper is allergic to this medication____

Describe reaction and what is done to manage it: ____

☐ This camper is allergic to this food(s): ____

Describe reaction and what is done to manage it:_________ ____

Severity of Allergy: ____

☐ This camper is allergic to the following: ____

Describe reaction and what is done to manage it:_________ ____

Diet: Sonlight serves family style meals. We can work with some medically prescribed diets, but do not cater to individual food preferences. Call if you have questions about your camper's diet.

☐ No red meat ☐ No pork ☐ No eggs ☐ No poultry ☐ No gluten ☐ No seafood ☐ No dairy

☐ Other (describe)______________________________

If any boxes are checked, please clarify if this is a diet preference, an intolerance or allergy and reactions ________________________________

____

Chronic Concerns: Check all that pertain to this camper and describe how you handle at home.

□ 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 □ Seizures □ Diabetes □ Bedwetting □ Menstrual cramps □ Frequent colds □ Other (please describe:)____________________________

Information about items above (attach additional information if needed):
____

____

Mental and Emotional Health:

Has this individual gone through any significant family changes? (death, divorce, abuse, adoption etc…) □ Yes □ No
Comments____

____

____

Is there anything you would like us to know so that we may work with you to provide the best camp experience for your child?

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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.

Medication	Reason for Taking it	Dose Given and When	Date Started?
		☐ Breakfast dose: ____________________ ☐ Evening Meal Dose: ____________________ ☐ Bedtime Dose: ____________________ ☐ Other: ____________________	
		☐ Breakfast dose: ____________________ ☐ Evening Meal Dose: ____________________ ☐ Bedtime Dose: ____________________ ☐ Other: ____________________	

		☐ Breakfast dose: ______________________________ ☐ Evening Meal Dose: ___________________________ ☐ Bedtime Dose: _______________________________ ☐ Other: _____________________________________	

Health Center Medications: These medications are stocked by Sonlight, used to help manage common illness or injury. They are administered as directed by our medical protocols. Cross out those which your camper should not be given.	**Resident camp** Acetaminophen *(Tylenol)* Nix Opcon-A eye drops Loratadine *(Claritin)* Ibuprophen *(Advil)* Calamine Lotion Chamomile Tea Generic cough drops Guaifeesin DM (Mucinex¨ products; Robitussin Cough & Cold CF Liquid)	Anti-Diarrheal *(Maalox)* Tums antacid Kaopectate Epinepherine 1:1000 Diphenhydramine *(Benadryl)* Chlorpheneramine Maleate *(Robitussin cough and allergy syrup)* Tolnaftate *(Tinactin)* Pseudoephedrine Hydrochloride (Advil¨ Cold & Sinus products) Zyrtec (Cetirizine)	**High Adventure and Outcamp Trips** Acetaminophen *(Tylenol)* Ibuprofen Tums antacid Diphenhydramine *(Benadryl)* Pseudoephedrine *(Sudafed)* Loratadine Epinepherine 1:1000

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. (Some provide no insurance). Parent/ guardians are financially responsible for healthcare given by an out-of-camp provider for any amount not covered by the Sonlight policy. To whom should the out-of-camp provider route the charges for a camper/staff member healthcare?

Send healthcare bills to: ____

Mailing address: ____