Camp GROW Health Form

The GARD Center
Phone: 268-463-4121
Fax: 268-562-0084
Email: admin@gardc.org
www.gardc.org

EAG
Phone: 268-724-5411
Email: eag@candw.ag
www.eagantigua.org

Team Fresh Produce Cooperative
Phone: 268-770-9871

Camper's Name: _____
(please print FULL name)

Gender: M F Camper's Date of Birth: _____
(Day / Month / Year)

Mailing Address: _____

Parent / guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship to Camper: _____
(please print FULL name)

Email: _____ Cell Phone: _____

Work Phone: _____ Home Phone: _____

Second parent / guardian or other emergency contact:

Name: _____ Relationship to Camper: _____
(please print FULL name)

Email: _____ Cell Phone: _____

Work Phone: _____ Home Phone: _____

Additional contact in event parent(s) / guardian(s) cannot be reached:

Name: _____ Relationship to Camper: _____
(please print FULL name)

Email: _____ Cell Phone: _____

Work Phone: _____ Home Phone: _____

Allergies

☐ No known allergies

☐ Food Allergies ☐ Environmental Allergies ☐ Medicinal Allergies ☐ Other

Please describe below what the camper is allergic to and the reaction seen:

_____
_____
_____

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Diet / Nutrition

- ☐ This camper eats a regular diet.
- ☐ This camper eats a regular vegetarian diet.
- ☐ This camper has special food needs.

Please describe below what the camper's special food needs are:

_____
_____
_____
_____

Restrictions

- ☐ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
- ☐ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. (Please describe below)

Please describe below what the camper's special food needs are:

_____
_____
_____
_____

Medications

- ☐ This camper will NOT take any daily medications while attending camp.
- ☐ This camper will take the following daily medication(s) while at camp.

"MEDICATION" IS ANY SUBSTANCE A PERSON TAKES TO MAINTAIN AND/OR IMPROVE HEALTH. THIS INCLUDES VITAMINS AND NATURAL REMEDIES. ALL MEDICATIONS MUST HAVE LABELS WHICH SHOW THE CAMPER'S NAME AND HOW THE MEDICATION SHOULD BE GIVEN, AND BE ACCOMPANIED BY A DOCTOR'S ORDER. PROVIDE ENOUGH OF EACH MEDICATION TO LAST THE ENTIRE TIME THE CAMPER WILL BE AT CAMP.

Name of Medication	Date Started	Reason for Taking It	When is it given?	Amount or Doses Given	How it is given

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What have we forgotten to ask?

Please provide in the space below any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. Attach additional information if needed.

Parent / Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me. If I cannot be reached in an emergency, I give my permission to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Parent or Custodial Parent / Guardian Signature | Date (Day / Month / Year) | Relationship to Camper