

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.

Name of Medication	Reasons for Taking it	Dose Given & When	Date Started?
		<input type="checkbox"/> Breakfast dose: _____ <input type="checkbox"/> Evening Meal Dose: _____ <input type="checkbox"/> Bedtime Dose: _____ <input type="checkbox"/> Other: _____	
		<input type="checkbox"/> Breakfast dose: _____ <input type="checkbox"/> Evening Meal Dose: _____ <input type="checkbox"/> Bedtime Dose: _____ <input type="checkbox"/> Other: _____	
		<input type="checkbox"/> Breakfast dose: _____ <input type="checkbox"/> Evening Meal Dose: _____ <input type="checkbox"/> Bedtime Dose: _____ <input type="checkbox"/> Other: _____	

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)		

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.

- | | | | |
|---|-----------------------------|------------------------------------|--------------|
| Acetaminophen (<i>Tylenol</i>) | Kaopectate | Loratadine | Tums antacid |
| Calamine Lotion | Ibuprophen | Nix | |
| Chlorpheniramine Maleate (allergy medication) | Generic cough drops | Opcon-A eye drops | |
| Diphenhydramine (<i>Benadryl</i>) | Guaifeesin DM (cough syrup) | Pseudoephedrine (<i>Sudafed</i>) | |

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: _____

When You Aren't Available—If we cannot reach you, provide contact information for other people who know your child and with whom we can consult. **Two alternate contacts are required by Colorado childcare regulation.**

Alternate contact: _____ Phone: (_____) _____ Relationship to camper: _____

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Authorizations:

There are 4 authorizations below. Please initial each , and then sign and date

Parent/Guardian Authorization for Healthcare:

_____ **(initials)** 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 have received and read the letter from the camp director regarding activities my child/myself might participate in. 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 ambulance or 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 food service staff, and/or counseling staff. I understand that Sonlight is in a rural environment. Treatment for me/my child by a physician may be hours from Sonlight resident camp, and much longer for excursions or outcamps. This form may be photocopied.

Authorization for Rafting *(For Sonlight camps only. Not all groups that use Sonlight offer rafting)*

_____ **(initials)** I hereby grant permission for my child to participate in whitewater rafting facilitated by Sonlight Adventures, Inc., and contracted to a rafting company. I understand that my child will be traveling by bus to an offsite location for rafting.

Authorization for Photos

_____ **(initials)** I give my permission for the photos taken of me/my child participating in camp activities to be used for the promotional purpose of camp, and Sonlight, to include the website.

Acknowledgement of Risk

_____ **(initials)** I understand that camp can have certain inherent risks, that the mountain environment is different than the city, that situations may arise which will be dealt with differently than in an urban area. I understand that cell phones and other electronic devices may not be used at Sonlight or on the wilderness or backpack trips.

Signature of Parent/Guardian or Adult Participant: _____ Date: _____



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 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 2 years 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: _____

Signature of Physician or Nurse Practitioner: _____
Printed Name: _____
Address: _____
Phone: (_____) _____ Date of exam: _____ Date of Signature: _____

Sonlight Nursing Notes

_____ Screening conducted according to Sonlight protocols, and significant findings noted.
date/time

- 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

Screening done by _____

This child may **not** leave camp with the following individual(s): _____

Exit Note Check one of the following:

- Left camp this day with no reported illness/injury Date: _____
- Left camp this day with the following problem/concern _____ Initial: _____

This problem was told to (name of responsible party) _____

Medications returned to: _____