

CAMPER HEALTH PROFILE

for HIGH PEAKS CAMP 2023 and LEADERSHIP CAMP 2023

To be completed by a parent/legal guardian. Must be returned by June 1.

Return via email to: atis@atistrail.org

Or return via mail to: ATIS, PO Box 565, Keene Valley, NY 12943



**** PLEASE ATTACH THIS ITEM WHEN SUBMITTING THIS FORM. ****

A copy of the most recent (within one year) physical exam. School forms are acceptable.

Camper's Name: _____

Date of Birth: _____ Date of last physical exam: _____

VACCINATION INFORMATION

Are all immunizations current?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If no, please explain:
Date of last Tetanus shot/booster:			
Date of last Meningococcal meningitis shot/booster:			
Has your child been vaccinated for Covid-19?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	

HEALTH INFORMATION

Include comments here; attach extra pages if needed.

ALLERGIES: Please indicate if the camper has any known allergies including to medicines, foods, plants, bites, stings, etc. Please list allergy reactions and medications.	<input type="checkbox"/> YES <input type="checkbox"/> NO	
RECENT ILLNESS OR INJURY: Please indicate if the camper has experienced any recent illness or injury and provide details.	<input type="checkbox"/> YES <input type="checkbox"/> NO	
MEDICATION: Please list any prescribed medication that the camper currently takes. If medications will be discontinued during camp, please indicate that.	<input type="checkbox"/> YES <input type="checkbox"/> NO	<i>Please indicate the medications that will be sent to camp: Medication / Condition / Dosage (Amount + Frequency) / Side Effects</i>

<p>** PLEASE SEND A <u>DOUBLE</u> SUPPLY OF ALL INHALERS AND OTHER PRESCRIPTION MEDICATIONS WITH YOUR CAMPER FOR THE DURATION OF CAMP. **</p>		
<p>ABILITY TO SELF-MEDICATE: If taking medications, the camper must be able to self-medicate according to the health care provider's directions. Please indicate if your camper is capable of this and add any related notes.</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>**Please <u>ATTACH</u> a note from prescriber attesting to the camper's ability to self-medicate.**</p>
<p>MEDICATION SCHEDULE: Is there a specific time identified for the camper to administer the medications? (For example, are the medications to be taken every morning before a hike?)</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>Please indicate what time(s) the camper is to administer each medication:</p>
<p>SPECIAL DIET: Is a special diet required for this camper? If so, please specify the diet and condition.</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>	
<p>HEARING, VISUAL, OR DENTAL CONDITIONS: Does this camper have any hearing, visual, or dental conditions requiring special attention?</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>	
<p>OTHER: Please indicate any additional medical conditions we should know about or concerns you have about your child's health. No concerns or limitations will necessarily disqualify a child from attending camp, but it is vital that we know in advance about any potential problems. Attach extra pages if necessary.</p>		

STATEMENT OF THE PARENT / LEGAL GUARDIAN

The information I have provided on this form is complete and correct to the best of my knowledge. I believe my child to be physically and emotionally capable of participating in all ATIS activities, and I grant permission for this participation, except where noted. I recognize that at times High Peaks Camp / Leadership Camp operates in remote, rugged terrain under a variety of weather conditions and that in the event of an emergency medical assistance will possibly be limited and/or delayed. I attest that my child is able to self-administer the medication as specified above. I also authorize the staff of ATIS High Peaks Camp / Leadership Camp to remind my child to administer his/her medication as specified.

Signature of parent or legal guardian: _____ Date: _____

EMERGENCY AUTHORIZATION

In the event of an emergency, ATIS will make every reasonable effort to contact you. To ensure that necessary treatment is not delayed:

I hereby grant permission to ATIS:

1. To have access to my son / daughter's medical information included on this form.
2. To select medical personnel and to order X-rays, routine tests, or treatment for the camper identified above.
3. To make relevant medical information available to medical personnel.
4. To provide first aid during ATIS sponsored activities.

I hereby grant permission to the health care provider selected by ATIS to: hospitalize, secure and administer treatment as deemed necessary, and order injections and/or anesthesia and/or surgery for the camper named above:

Signature of parent or legal guardian: _____ Date: _____

Signature of witness: _____ Date: _____

INSURANCE

Participants in ATIS programs are responsible for their own medical expenses. We therefore ask for your insurance information in case we are required to present it to a medical provider who treats your child during an emergency.

Does your insurance company require preauthorization?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Name of your insurance company:	
Name of your policy holder:	
Policy #	
Group #	
Insurance Company Phone Number:	

CONTACT INFORMATION

Name of Parent or Legal Guardian:	Local Address:	Cell Phone: Home Phone: Work Phone:
Name of Second Parent or Legal Guardian:	Local Address:	Cell Phone: Home Phone: Work Phone:
If the people above are not available in an emergency, notify:	Relationship to Camper:	Cell Phone: Home Phone: Work Phone: