

Camper Medical Form

Trail's End Ranch

Sports and Adventure Camp

P.O. Box 460, Ekalaka, MT 59324 (406) 775-6401 fax: (406) 775-6441 ter@midrivers.com www.ter.org

Personal Information

Circle one: Male Female

Name _____ Date of Birth ___/___/___ Age at camp ___ Soc. Sec. No. _____

Permanent Address _____
Street Address City State Zip

Campers E-mail Address _____ Parents E-mail Address _____

Emergency Contact: _____ Relationship _____
Home Phone _____ Business Phone _____

Secondary Emergency Contact: _____ Relationship _____
Home Phone _____ Business Phone _____

Mother's Name _____ Phone _____ Occupation _____

Father's Name _____ Phone _____ Occupation _____

Doctor _____ Phone _____

Medical History (attach additional page if necessary)

Serious illnesses, surgeries, recent broken bones, childhood diseases, etc (include dates):

History of psychological or behavioral problems (violence, attempted suicide, uncontrolled anger, sexual misconduct, etc.)

Allergies (medications, food, animals, etc.):

Restrictions (activities, diet -- what & why):

Medical or behavioral problems for us to watch for:

Medication/Immunization Information

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name, dosage and frequency of administration of medication.

This person takes NO medications on a routine basis.

This person takes medications as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Identify any medications taken during the school year that participant does/may not take during the summer.
Use separate sheet to list additional medicines.

Has camper been adequately immunized for: Polio _____ Mumps _____ DPT _____ Measles _____ Tetanus _____
Date

Permission To Provide Necessary Treatment and/or Emergency Care

I give my permission to medical personnel selected by Trail's End Ranch to provide routine health care, to dispense needed over-the-counter drugs and prescription drugs brought by the camper, and give any emergency medical attention necessary for _____ . Any exceptions to this are specifically listed here: _____ .

Camper's Name _____

Signature _____ Date _____

parent or guardian must sign unless participant is over 18 years old and able to sign for himself/herself

Medication/Treatment Disclaimer

I understand that if _____ refuses to follow medication schedule and/or doctors orders, Trail's End Ranch can make the decision to send the camper home. There will be no reimbursement of camp fees in such cases.

Signature _____ Date _____

parent or guardian must sign unless participant is over 18 years old and able to sign for himself/herself

Insurance Information, Authorization & Contract For Services

Is the participant covered by family medical/hospital insurance? Yes No

Carrier/Plan Name _____ Group # _____

Carrier Address _____

Name of Holder _____ Relationship to Camper _____

Social Security #/Insurance ID Number of Policy Holder _____ Birth date of Policy Holder ___/___/___

I authorize release of information required to complete the proper insurance forms by the medical provider as appropriate. I also authorize and direct all insurance companies to pay all benefits directly to the medical providers as appropriate. I also understand that even though I have assigned all benefits to the provider, I remain financially responsible for the payment of my account, regardless of insurance determinations.

Signature _____ Date _____

Responsible Party

Please note that all guests are expected to use their own health and accident insurance at camp.
A limited policy is carried to cover those who have no insurance, but Trail's End Ranch assumes no liability above these limits.

Behavior Disclaimer

I understand that if _____ refuses to obey the camp rules or causes disruption of the camp through his/her behavior, we will be contacted and the camper sent home at our expense. There will be no reimbursement of camp fees in such cases.

Signature _____ Date _____

parent or guardian must sign unless participant is over 18 years old and able to sign for himself/herself

Screening Record (For Camp Use Only)

Date Screened: _____ Time: _____ am pm Meds Received Yes No

Current Health Needs: _____

Observational Notes: _____

Screened By: _____