****Note to parents: Please make sure that your forms are filled out completely. Originals will be the only accepted documentation. Your child's forms must be received in the Arthritis Foundation office no later than June 1, 2016. No exceptions.**

Personal Medical History

It is important for the Camp Joint Adventures Medical Staff to know the health condition of the camper before camp. We appreciate your time and care in completing this form. The confidentiality of your answers will be respected. **Please complete all sections clearly.**

CAMPER'S NAME____

PARENT/GUARDIAN NAME ____

PARENT PHONE NUMBER ____

DATE OF BIRTH________ HEIGHT_____in. WEIGHT_____lbs.

Physician Contact Information

RHEUMATOLOGIST'S NAME____

PHONE #(__________)____

RHEUMATOLOGY OFFICE ADDRESS ____

RHEUMATOLOGY NURSE'S NAME____

FAMILY PHYSICIAN'S NAME____

PHONE #(__________)____

Health Insurance

Insurance Coverage for camper accidents or illnesses while participating in programs at Camp Joint Adventures is the responsibility of the camper's family. Please include a copy (front and back) of any health insurance card(s) that you would like used in case of emergency.

HEALTH INSURANCE CARRIER____

POLICY #______________________________ID#______________________________

NAME OF INSURED____

HEALTH INSURANCE CARRIER TELEPHONE # ____

Immunizations

Are immunizations up to date? YES__________NO___________

DATE OF LAST TETANUS BOOSTER:____

Please contact your child's doctor's office to get this information.
It is crucial for us to have this information!!

Health History

What is your child's rheumatic (arthritis) diagnosis or diagnoses?

____

____

At what age or year was he/she diagnosed?______________ Date of last flare-up? ______________________

What particular areas are involved in typical flare-ups?_____________________________________

____

What complications, if any, has your child experienced?___________________________________

____

Does your child have activity restrictions? If so, please describe – this could include walking, sitting on the floor, etc.____

____

____

____

Other Medical History Information

Please check any of the following illnesses if ever experienced by your child: if yes, then report the last date your child was treated for the problem and discuss in the space provided.

______ **None – if "none" please check this box**

Seizure _________________________ ***TB***_____________________ ***Diabetes***______________________

Gastritis_________________________ ***Migraines***________________ ***Thyroid problems***________________

Ulcers__________________________ ***Hepatitis***_________________ ***Hypertension***___________________

Chicken pox_____________________ ***Asthma***__________________ ***Other lung problems***_____________

Bleeding problems________________ ***Heart problems***____________ ***Behavior problems***_______________

ADHD ___________________________ ***Depression*** _______________

Psychiatric Illness (Must Define Below) _________________________

Other____

Explanations:____

____

If there is a behavior/psychiatric illness, how is it managed? Do you have tips on how to handle this at camp? :____

____

Diet

Please describe any special diet or dietary restrictions:_________________________________

____

______ **No Diet Restrictions – if "none" please check this box**

Allergies

Is your child allergic to *anything* (foods, insects, medication, etc)? YES NO (circle one)
If you answered YES please complete below. If you answered NO please skip to the “Medications” section (next page).

We want to ensure that your child has a wonderful, safe experience at Camp Joint Adventures.

Please complete the table below for each medication, food, or environmental (e.g. pollen, bee/wasp) allergy that your child has.

Be as specific as possible and include detailed information about how the allergy has been handled in the past- for example, antihistamines (Benadryl) steroids, epipen, emergency room visit, etc.

Use the back of the page if more space is needed.

Allergic to what?	Type of Allergy: Medication, Environment or Food?	What was the reaction?(rash, swelling, trouble breathing)?	When was the last time the reaction happened?	If applicable, how do you handle this allergy at school?	How do you handle the reaction (medications used, restrictions, etc)?

Medications

Please list all your child's **medications and vitamins**, including **commonly used over-the-counter medications**. Please be exact with doses, times given and ways the medicine is given. (See example)

EXAMPLE OF MEDICATION LIST

MEDICATION/ VITAMIN (name/dose in mg or ml (cc)-See bottle label)	HOW MANY TIMES GIVEN AND HOW	WHEN (Day & Time)
Methotrexate 25mg/ml	*0.5 ml by sq shot*	*Friday 7 PM after dinner*
Naprosyn 250 mg tabs	*1.5 tabs by mouth*	*8 AM and 7 PM after meal*
Albuterol Inhaler	*2 puffs inhaled*	*4x a day before exercise*
Tylenol 500 mg tabs	*1 or 2 tabs by mouth*	*4x a day as needed for headaches*

Camper's Medication List

MEDICATION Name; Dose in mg or ml (cc)	HOW MANY ARE GIVEN AND HOW (by mouth, IM or SQ)	WHEN Day, Time	SPECIAL PROCEDURE

The table above should MATCH the medications prescribed by your child's rheumatologist, as well as the medications your child brings to Camp Joint Adventures. Let us know PRIOR TO CAMP if the medications have changed

We may need to give an over-the-counter medication that you have not sent along to Camp. Please review the following list of medicines and mark yes if we have permission to give it to your child.

Over-the-Counter Medication	Yes	No
acetaminophen/Tylenol (for pain, headaches, fever)		
Calamine (for itching, bug bites)		
Benadryl Cream or Spray (for itching, bug bites)		
Benadryl elixir or tablets (for allergic reactions)		
Sunscreen		
Eye Wash (for itching, irritation, redness)		
Tums or antacids		
ibuprofen		
Aloe Vera		
Hydrocortisone Cream		
Antibiotic ointment		

PARENT OR GUARDIAN MEDICAL AUTHORIZATION

The information supplied on each of the forms provided to the Arthritis Foundation, Heartland Region, Camp Joint Adventures is correct to the best of my knowledge, and my by my signature I give permission for the Camper identified below to participate and engage in all prescribed camping activities, except those noted by the examining physician and myself. In the event a medical issue arises, my child will be directed to the onsite medical staff person, who will contact me to discuss next steps.

Camper's Full Name:____

Signature of Parent or Guardian:__________________________________

Parent or Guardian Printed Name:_________________________________

Date:____

Authorization to Consent to Hospital Medical Treatment for Minor Child

I, (we) ________________ and __________________ of ___________________
name *name* *city*

________________County, _______________, do hereby state that I am (we are)
county *state*

the natural parent(s) or legal guardian(s) having legal custody of

________________________________, a minor, age____, born ____/____/________
child's first & last name

who resides with me (us) at ____
address

I (we) authorize the physicians of the Emergency Department along with appointed consultants to perform all diagnostic studies including the administration of anesthesia, blood transfusions, all medical and/or dental treatment including immunization against disease and emergency surgical intervention which might be deemed necessary or advisable for the best interest of the Camper.

Dated this ___________________ day of __________________________, 20________

Allergies______________________________ Religion_________________________

Signed 1 ______________________________ Signed 2 _________________________

Witness__________________________

Effective Date:_____________________ Expiration Date: 6/25/2016