youthhelpers.com Youth Helpers is a non-profit 501 (c)(3) organization
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to grow and discover LAUREL PINES VIP AND CONFERENCE GROUNDS

YOUTH HELPERS FOR THE KIDS

MEDICAL CONSENT / HEALTH FORM

CAMPER INFORMATION

We must have Medical Consent/Health Form completed and signed by the parent or legal guardian for each camper under age 18 attending Youth Helpers, Inc.

Child's Name_____ Age _____ D.O.B. _____ Gender: M F
Address_____ City _____ State _____ Zip_____
Parent/Guardian Name:_____
Day Time Phone_____ Cell Phone_____
Parent/Guardian Name:_____
Day Time Phone_____ Cell Phone_____

Emergency Contact: _____
Day Time Phone_____ Cell Phone_____

REQUIRED MEDICAL INFORMATION

We REQUIRE this information to provide appropriate medical care in event of injury and/or illness while at camp. We are committed to protecting the confidentiality of this information.

Do you carry medical/hospital insurance? Y / N Insurance Carrier_____ Policy # _____
Insurance Phone (_____) _____Name of Responsible Party _____
Family Physician _____ Phone (_____) _____

HEALTH HISTORY

General Questions: Check "Yes" or "No" for each statement. Has the camper:

Has / Does Your Child?	No	Yes		Has / Does Your Child?	No	Yes
1. Ever been hopitalized or had surgery?				15. Ever been dizzy/passed out during or after exercise?		
2. Have recurrent / chronic illness?				16. Ever had chest pain during or after exercise?		
3. Had a recent illness or infectious disease?				17. Ever been diagnosed with heart murmur?		
4. Wear glasses, contacts or protective wear?				18. Ever had high blood pressure?		
5. Have a history of bed wetting?				19. Ever had back problems?		
6. Have any skin problems (rash, itching, etc)?				20. Ever had problems with joints (knee, ankles, etc)?		
7. Have diabetes?				21. Have an orthopedic appliance being brought to camp?		
8. Have asthma/wheezing/shortness of breath?				22. Had fainting or dizziness?		
9. Have frequent headaches?				23. Had mononucleosis(mono) in past 12 months?		
10. Had a head injury/been knocked unconcious?				24. Have problems with diarrhea/constipation?		
11. Ever had seizures?				25. Have a history of sleepwalking?		
12. Ever been diagnosed with migranes?				26. If female, any problems with menstrual history?		
13. Have allergies (seasonal, food, mediation, etc)?				27. Ever had any emotional problems for which		
14. Ever had an eating disorder?				professional help was sought?		

Please explain "Yes" answers in the space below, noting the number of the questions. (use back or additional sheet if necessary)
_____

IMMUNIZATIONS: Please fill in the information below **or attach a recent copy of your child's immunization record**.
1. All immunizations up to date: Yes No **2**. Polio (OPV or IPV) ……..Date _____ **3.**Varicella (Chicken Pox)…….Date _____
4. DTP/DTap/DT/TD (Diphtheria, Tetanus, Acellular Pertussis or Tetanus and Diptheria only)……..Date _____
5. MMR (Measles, Mumps, Rubella)……..Date _____ **6.** Hepatitis B ……..Date _____

Please List ALL Allergies: Drug_____Insect/Plant_____
Food_____ Diet Restrictions_____
List ANY Medications Camper will require at camp and reason. (Prescriptions medications **MUST** have completed medical form)
_____

PARENT/GUARDIAN PLEASE READ AND SIGN BELOW:

ALL prescription medications, over-the-counter medications, vitamins, and herbal products that are provided for staff to administer to your child **MUST be in ORIGINAL containers with labels and dispensing instructions in English and COMPLETED medical form signed by doctor for all prescription medication**.

PERMISSION TO ADMINISTER OVER THE COUNTER MEDICATIONS: In event of minor illness at camp, I give my informed consent to the First Aid personnel to provide basic First Aid and comfort measures which include the use of common over-the-counter remedies in appropriate age/weight dosages. I authorize the use of /but not limited to the following over-the-counter medications as directed by the labels provided by the manufacturer for my child: analgesics, decongestants, antihistamines, cough suppressant, throat lozenges or spray, anti-nausea/diarrhea, epi-pen, antacid, antibiotic ointment, hydrocortisone cream, burn cream, petroleum jelly, chapped skin/lip treatment, antiseptic skin/wound cleansers, ipecac, glucose, laxatives, electrolyte replacement fluids, analgesic balms/gels. I understand that these are stocked and dispensed by personnel free of charge as needed for the comfort of my child.

PERMISSION TO TREAT: I, the undersigned parent or legal guardian of the child named above, do hereby authorize and consent Youth Helpers, Inc., to provide to the above name child routine health care and to administer medications as detailed above. It is understood that in the case of an emergency every effort will be made to contact the undersigned prior to rendering treatment to the patient, but treatment will not be withheld if the undersigned cannot be reached. In case of emergency I authorize Youth Helpers, Inc. to order any x-ray examination, anesthetic, medical or surgical treatment rendered by medical or emergency professionals licensed under the provisions of the Medicine Practice Act, or dentist licensed under the provisions of the Dental Practice Act and on the staff of any general hospital in the state of CA, Department of Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care deemed advisable by aforementioned physician in the exercise of the doctor's best judgement. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of CA. I authorize Youth Helpers to arrange for or provide any necessary related transportation to the nearest medical facility for urgent or emergency medical treatment if indicated, and I do assume all responsibility for payment for such treatment. This completed form may be photocopied for trips away from camp.

I acknowledge that I have read completely and fully understand all aspects of this form and I agree to the terms contained within them in their entirety.

PARENT/GUARDIAN SIGNATURE:_____ **Date**_____