Missouri Children's Burn Camp®

Health Form for Children Part One (To be completed/signed by Parent/Guardian)

Camper Name_____Male_____Female_____Date of Birth _____

Camper Preferred Name _____Camper's Social Security_____ Home Address_____

_____

City _____ State _____ Zip _____

Parent/Guardian Name(s)_____ Relationship to Camper_____ Address (if different than camper's)_____

Home Telephone Number _____ Work Telephone Number _____

Email Address for Camper

_____

Emergency Contact_____ Telephone Number _____

Insurance Information

Is the camper covered by family medical insurance? _____ yes _____ no

Name of Carrier_____

_____ Carrier Address_____

_____ Carrier Phone Number_____

Name of Insured _____

Relation of Camper to Insured _____

Plan Name, Group Number and Policy Number

_____

Emergency Treatment Release

I hereby authorize the medical personnel chosen by Burns Recovered Support Group, Inc. to secure and administer treatment for my child in the event of a medical emergency. This treatment may include, but may not be limited to transportation, x-rays, routine tests and other necessary treatments.

Signature of Parent/
Guardian_____ Date
_____

Health History
List any allergies camper is known to have
_____
_____
_____

List any medications camper is currently taking and dosage (*If medicines are to be sent to camp, they must be in their

original container.)

Has the camper ever
Yes
No
(Please explain “yes” answers on
1.
Had any recent illness or injury?
___
___
the back side of this page.)
2.
Been exposed to a communicable disease?
___
___

3.
Been hospitalized for reason other than burn injury?
___
___

4.
Had a chronic or recurring illness or condition?
___

___

5.
Had a head injury or been knocked unconscious?

___
___

6.
Had recurring headaches?

___
___

7.
Worn glasses or contacts?

___
___

8.
Passed out, been dizzy or had chest pain after?

___
___

9.
Had seizures?

___
___

10.
Been diagnosed with any type of heart problem?

___
___

11.
Had high blood pressure?

___
___

12.
Been diagnosed with bleeding/clotting disorders

___
___

13.
Had back or joint problems?

___
___

14.

Had frequent ear infections?

___

___

15.

Been diagnosed with asthma?

___

___

16.

Been diagnosed with diabetes?

___

___

17.

Has your child menstruated? (For Girls Only)

___

___

18.

Had emotional or behavioral difficulties for which

professional help was sought?

___

___

Please explain any "Yes" answers to the previous questions:

_____
_____

_____
_____

_____
_____

_____
_____

_____
_____

_____
_____

_____
_____

_____
_____

_____

_____

Indicate if child is currently or in the past had any of the items listed below. If yes, give approximate dates.

Yes
No

Yes
No
DTP

___

___
Polio

___

___
Tetanus/Diphtheria

___

___
Chicken Pox

___

___
Measles

___

___
Head Lice

___

___
German Measles/ Rubella

___

___
Mumps

___

___

Please use this space to provide any information about your child's medical and mental history about which we should be aware. Please include any physical, emotional, behavioral or mental health information.

_____

_____

_____

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_____
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_____
_____

I do not wish my child to participate in any of the following activities:

_____
_____
_____
_____

_____
_____

_____
_____

Name of family physician
_____
Phone number _____

Attached is a copy of <u>my child's immunization record</u>, including when the child received the shots. (A COPY of school records is acceptable, please <u>do not send original</u>).

I certify that the health history provided above is correct and complete as far as I know. Unless otherwise noted, below, my child has my permission to take part in all scheduled camp activities with no restrictions. I hereby give permission to the nurse or other medical personnel selected by Burns Recovered Support Group/Missouri Children's Burn Camp (BRSG/MCBC) to obtain and administer any surgical and medical treatment, or hospitalization needed in the case of an emergency for my child named above. I agree that BRSG/MCBC or their authorized agents may administer over-the-counter medications, or their generic equivalent, as deemed necessary such as but not limited to: Calamine lotion, Betadine, Milk of Magnesia, Pepto Bismol, aspirin, Tylenon, Neosporin Ointment, sun block, Sucretes, sting ointment, Blixtex and Visine.

Parent/Guardian Signature

_____

Date _____

NOTE: Please return this and all other forms to the address below by July 1

Burns Recovered Support Group, Inc.
11710 Administration Dr., Suite 2B
St. Louis, MO 63146

Missouri Children's Burn Camp Health Care Record 2008

Camper Name

_____

Medicines brought to camp_____

_____

_____

_____

_____

_____

_____

Dosage Notes

_____

_____

_____

_____

_____

_____

Visits to Medical Facility

Date Reason Activity

Notes

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Signature of Camp Nurse_____

Date

_____

_____

Health Form for Children Attending Missouri Children's Burn Camp

Part Two (To be completed/signed by a Licensed Medical Professional)

This examination is for determining fitness and general health to engage in a variety of basic activities while at Missouri Children's Burn Camp.

Camper Name
_____
_
Male _____
Female _____
Date of Birth _____
Child's Weight _____lbs
Height_____
Blood Pressure_____

I have examined the above Missouri Children's Burn Camp participant.

Date of last examination
_____
____

In my opinion, the above camp applicant _____ is _____ is not able to participate in an active camp program.

It is possible that transportation to camp will be via private small aircraft. In my opinion, this child is medically stable and

_____is _____ is not able to fly in a non-pressurized small aircraft

Health Recommendations/Restrictions
The applicant is under the care of a physician at this time for the following reasons:
_____

_____
_____

_____
_____

Current treatment includes:
_____
__

_____
_____
_____
_____

_____

Known allergies:

_____

Description of any limitations or restrictions on camp activities:

_____

_____

_____

_____

Please provide us with any additional information for the Missouri Children's Burn Camp health care staff which might prove to be beneficial:

_____

_____

_____

_____

_____

_____

Signature of Licensed Medical Professional

_____

Please print name

_____

Title

_____

_____

Phone __(_____)_____ Date

_____

You may fax this to: (314) 997-0903