

**Illinois Rainbow Leadership Camp Health Form**

Name \_\_\_\_\_

Birth date \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Home

Work

Cell

Pager

**EMERGENCY CONTACTS**

1. \_\_\_\_\_

name

home phone

alternate way to contact \_\_\_\_\_

2. \_\_\_\_\_

name

home phone

alternate way to contact \_\_\_\_\_

**MEDICAL HISTORY**

Diabetes \_\_\_\_\_ Epilepsy/seizures \_\_\_\_\_ HTN \_\_\_\_\_

Cardiac \_\_\_\_\_ LungDisease \_\_\_\_\_ Asthma \_\_\_\_\_

Renal Disease \_\_\_\_\_ Cancer \_\_\_\_\_ Ulcers \_\_\_\_\_

Thyroid \_\_\_\_\_ Chickenpox \_\_\_\_\_ Measles/Mumps \_\_\_\_\_

Swimmer's ear \_\_\_\_\_ Ear infections \_\_\_\_\_

Cold/Cough/Sore Throat (last 2 weeks) \_\_\_\_\_

Pertinent family history \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PAST HOSPITALIZATIONS/SURGERIES**

Please include month and year  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IMMUNIZATIONS**

Up to date: yes/no

Last Tetanus: \_\_\_\_\_

**RESTRICTED ACTIVITIES**  
\_\_\_\_\_  
\_\_\_\_\_

ALLERGIES (please include child's reactions)

Meds \_\_\_\_\_ Food \_\_\_\_\_ Contact \_\_\_\_\_ Latex \_\_\_\_\_

List: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS:**

(Please bring all medications in original bottle we must know about everything including over the counter medications (see reverse for specific over the counter medications))

Medication    dose    frequency    use  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HOME DIET:**

Home diet: \_\_\_\_\_

Please list all special diet requirements (i.e. Vegetarian, dairy intolerance, no caffeine, etc.)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PRIMARY PHYSICIAN:** \_\_\_\_\_  
\_\_\_\_\_

**ADDRESS** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**INSURANCE:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_

**Parental Suggestions:**  
\_\_\_\_\_  
\_\_\_\_\_

**PARENT/GUARDIAN AUTHORIZATION:** This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities, except as noted by me. I understand that the Illinois Rainbow Leadership Camp staff includes a Registered Nurse and Certified First-Aiders who will give care for usual & common medical issues and refer to the doctor on call as needed, should such an occasion arise.

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**CAMPER SIGNATURE:** \_\_\_\_\_

**PLEASE COMPLETE REVERSE SIDE OF THE FORM**

**Illinois Rainbow Leadership Camp Health Form**

The Illinois Rainbow Leadership Camp Nurse, Stacy Newton, RN, BSN, has my permission, should the need arise, to administer the following over the counter medications to my child, \_\_\_\_\_, (note, generic brand medications will be given):

- |                                 |                                  |
|---------------------------------|----------------------------------|
| ___ Acetaminophen (Tylenol)     | ___ Ibuprofen (Advil, Motrin)    |
| ___ Naproxen (Aleve)            | ___ Sinus/Allergy Tabs (Sudafed) |
| ___ Diphenhydramine (Benadryl)  | ___ Cough Syrup (Robitussin)     |
| ___ Calamine lotion             | ___ Maalox                       |
| ___ Mylanta                     | ___ Milk of Magnesia             |
| ___ Tums                        | ___ After bite bug bite relief   |
| ___ Rhuli Gel (Itch relief)     | ___ Triple antibiotic ointment   |
| ___ Cortisone 10 cream          | ___ Midol (menstrual relief)     |
| ___ Chloraseptic spray/lozenges | ___ After sun (sun burn relief)  |

Signed: \_\_\_\_\_, Parent / Legal Guardian Date: \_\_\_\_/\_\_\_\_/\_\_\_\_.

The following **OPTIONAL** Emergency Authorization is suggested by BroMenn Medical Center, Normal, Illinois (the hospital closest to Camp)

AUTHORIZATION FOR EMERGENCY MEDICAL AND/OR SURGICAL TREATMENT FOR A MINOR CHILD AND DESIGNATION OF PERSON AUTHORIZED TO GIVE SUBSTITUTE CONSENT FOR TREATMENT OF A MINOR CHILD

KNOW ALL MEN BY THESE PRESENTS that I (we), of (city) \_\_\_\_\_, In the County of \_\_\_\_\_ and State of Illinois, do hereby direct BroMenn Healthcare to accept the consent of Stacy Newton R.N.,BSN, Illinois Rainbow Leadership Camp Nurse, an adult, for any and all medical treatment which may be needed by my child, \_\_\_\_\_, when I (we) am (are) unavailable and efforts to contact me (us) are unsuccessful. I hereby authorize Stacy Newton R.N., BSN, Illinois Rainbow Leadership Camp Nurse, to make any and all necessary health care decisions on behalf of my child which may be required during my daughter's attendance at Illinois Rainbow Leadership Camp, June 21-27, 2009.

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN

DATE \_\_\_\_\_

WITNESS **OR** NOTARY

\_\_\_\_\_  
SIGNATURE OF WITNESS **OR** NOTARY

DATE \_\_\_\_\_

\_\_\_\_\_  
Relationship of Witness

**OR**

Notary Stamp