PARTICIPANT HEALTH FORM 2024

Last Name _____ **First Name** _____ **Gender** _____

Health Insurance Carrier_____ **Birth Date** _____ **Age** _____

INSTRUCTIONS FOR PARENTS/GUARDIANS AND ADULT PARTICIPANTS

1. All Sky Ranch campers must complete this form in full. A new form must be submitted each year.
2. **A Health Care Provider's signature is required for all participants**. A Healthcare Provider is a Nurse Practitioner, Physician Assistant, Medical Doctor, or Doctor of Osteopathic Medicine (NP, PA, MD, DO).
3. All participants must have a physical exam within 24 months of their week at camp. If a physical exam is needed, please bring this form to the appointment. If the camper has seen the provider in the last 24 months, most doctor's offices will complete and sign the form without an appointment.
4. **Participants without a Healthcare Provider signature are not eligible to participate in Sky Ranch programs.**
5. **This form is due three weeks prior to your arrival at Sky Ranch.**

HEALTH HISTORY

1. Please complete the health history for the participant. **Clearly describe any limitations, dietary restrictions, and allergies. You may attach more information if needed.**
2. If the participant has **Asthma** or has a prescription for an **Epinephrine Auto-Injector (Epi-Pen or Twinject)**, then you must complete an Asthma Care Plan or Epi-Pen Care Plan. Please find these forms at www.skyranchcolorado.org.

MEDICATIONS

1. All routine medications, including prescriptions, over-the-counter medications, and vitamins **MUST** be listed on the Health Form. This section must be completed by your healthcare provider.
2. Please ensure that accurate instructions and dosages are listed on the form. Sky Ranch **MUST** follow the written instructions on this form.
3. Please bring medications to camp in their original, non-expired containers—including vitamins and over-the-counter meds.
4. Sky Ranch stocks a healthcare center with over-the-counter medications. Please **cross off** the medications that should not be administered to the participant.

HEALTH HISTORY

CHRONIC CONCERNS

___ Seizures/Convulsions
___ Mononucleosis
___ Fainting/Dizzy Spells
___ Head Injury
___ Sleepwalking
___ Frequent Headaches
___ Diabetes
___ Heart Disease/Defect
___ Asthma **Please complete Asthma Care Plan**
___ High Blood Pressure
___ Frequent Ear Infections
___ Cancer
___ Bleeding/Clotting Disorder
___ Menstrual Problems
___ Kidney Disease
___ Developmental Delays
___ Learning Disability
___ Other

Please explain each item checked:

MENTAL/EMOTIONAL HEALTH

___ ADD/ADHD
___ Anxiety
___ Depression
___ Bipolar Disorder
___ Eating Disorder
___ Other

Please explain each i checked and share any other information that will help Sky Ranch care for your child: for your child:

_____
_____

DIETARY CONCERNS

____ Vegetarian
____ Vegan
_ ___ Lactose Free
_ ___ Gluten Free
____ Nut Free
____ Other

Please explain each item checked and share any other information that will help Sky Ranch care for your child: for your child:

_____

ALLERGIES

___ No Known Allergies ___ Insects ___ Foods ___ Medications ___ Other

Please describe allergen, reaction, and treatment. Attach more information as needed. If camper carries an EpiPen, please complete the EpiPen Action Plan.

_____

PARTICIPATION HEALTH FORM 2024

LAST NAME: _____ **FIRST NAME:** _____

MEDICATIONS—TO BE COMPLETED BY HEALTHCARE PROVIDER

Please complete the form with all medications (prescription, over-the-counter, vitamins) that will be brought to camp.

MEDICATION #1

Medication Name (EXACT NAME) _____ Dosage (mg/ml & tab/capsule) _____

Administration Time: As Needed ☐ AM ☐ PM ☐ Other _____ ☐ Taken with Food

Reason for Giving

(Special Instructions)

MEDICATION #2

Medication Name (EXACT NAME) _____ Dosage (mg/ml & tab/capsule) _____

Administration Time: As Needed ☐ AM ☐ PM ☐ Other _____ ☐ Taken with Food

Reason for Giving

(Special Instructions)

MEDICATION #3

Medication Name (EXACT NAME) _____ Dosage (mg/ml & tab/capsule) _____

Administration Time: As Needed ☐ AM ☐ PM ☐ Other _____ ☐ Taken with Food

Reason for Giving

(Special Instructions)

MEDICATION #4

Medication Name (EXACT NAME) _____ Dosage (mg/ml & tab/capsule) _____

Administration Time: As Needed ☐ AM ☐ PM ☐ Other _____ ☐ Taken with Food

Reason for Giving

(Special Instructions)

Please attach additional medications and instructions on a separate page.

STOCK OVER-THE-COUNTER MEDICATIONS

The following medications are stocked in the health clinic at Sky Ranch. These medications are administered by our volunteer health supervisor.

Please cross off any medications that SHOULD NOT BE GIVEN.

Acetampinophen/Tylenol	BZK Wipes	Immodium
Alcohol Wipes	Calamine Lotion	Insta-Glucose
Aloe Vera	Campho-Phenique	Saline Eye Wash
Anbesol	Cough Drops Cough	Sunscreen
Ammonia Inhalants	Syrup	Psuedoval/Sudafed
Antacids/Tums	Diphen/Benadryl	
Aquaphor	Emergen-C	
Antiobiotic Ointment	Gold Bond Powder	
BioFreeze	Hydrocortisone CR	
Bug Spray	Ibuprofen/Advil	

PARTICIPATION HEALTH FORM 2024

LAST NAME: _____ **FIRST NAME:** _____

IMMUNIZATIONS—TO BE REVIEWED BY HEALTHCARE PROVIDER

CERTIFICATE OF IMMUNIZATION
www.coloradoimmunizations.com

COLORADO
Department of Public Health & Environment

Colorado law requires this form to be completed by a school health authority or health care provider for each immunized student attending Colorado schools.

6 CCR 1009-2 The Infant Immunization Program and Immunization of Students Attending School: Schools shall have on file an official

Required Vaccines

Immunization date(s) MM/DD/YY

Hep B Hepatitis B							
DTaP Diphtheria, Tetanus, Pertussis (pediatric)							
Tdap Tetanus, Diphtheria, Pertussis							
Td Tetanus, Diphtheria							
Hib *Haemophilus influenzae* type b							
IPV/OPV Polio							
PCV Pneumococcal Conjugate							
MMR Measles, Mumps, Rubella							
Measles							
Mumps							
Rubella							
Varicella Chickenpox							

Varicella - date of disease		**Varicella** - positive screen date	

Recommended Vaccines

Immunization date(s) MM/DD/YY

HPV Human Papillomavirus							
Rota Rotavirus							
MCV4/MPSV4 Meningococcal							
Men B Meningococcal							
Hep A Hepatitis A							
Flu Influenza							
COVID-19							
Other							

Please attach Immunization Exemptions, Asthma Care Plans or Epi-Pen Action Plans. For questions, please call (970) 493-5258

PARENT/GUARDIAN RELEASE

I approve the over-the-counter medications on page 2 for use as needed by the participant. I have crossed off medications that are not approved for use by said participant.

I hereby request and give my permission to the Sky Ranch Lutheran Camp heath care worker to administer medication to the participant identified above. I understand that all medications must be provided in the original pharmacy labeled container. I understand my child assumes responsibility for going to the health clinic at specified times for medications.
I hereby give my permission to Sky Ranch Lutheran Camp to give care to the camper identified above in case of illness or injury and understand Sky Ranch Lutheran Camp will attempt to contact me in such event. Sky Ranch Lutheran Camp and its' staff have authorization to obtain medical treatment and procedures for the participant as may be appropriate in emergency circumstances, including treatment by physicians, hospital and clinic personnel, and other appropriate healthcare providers.

_____ _____

Signature of Parent , Guardian or Caregiver Date

HEALTHCARE PROVIDER RELEASE (NP, PA, MD, DO)—REQUIRED TO ATTEND CAMP

- I have approved the medications and dosages listed above for use by the camper identified above.
- I approve the stock over-the-counter medications listed on the front page for use as needed by the camper identified.
- I have examined the camper listed above within the last 24 months and have reviewed the health history. It is my opinion that this camper is in satisfactory condition and capable of engaging in all camp activities, unless noted otherwise.
- I have completed and reviewed the immunization record.

_____ _____ _____

Signature of Health Care Provider **Printed Name** **Date**

Provide Phone Number: _____

Provider Address: _____