PARTICIPANT HEALTH FORM 2026

Sky Ranch lutheran camp
www.skyranchcolorado.org
970-493-5258

PARTICIPANT (CAMPER) INFORMATION:

Last Name: _____ First Name: _____

Health Insurance Carrier: _____ Age: _____ Gender: _____

Dates of Camp Week: *(MM/DD/YY-MM/DD/YY)* _____ Program: _____ Birth Date: _____

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. Kindly fill out the health history for the participant, ensuring you detail any limitations, dietary restrictions, and allergies. If necessary, feel free to attach additional information.
2. If the participant has **asthma** or has a prescription for an **Epinephrine Auto-Injector (Epi-Pen or Twinject)**, it is required to complete either an Asthma Care Plan or an Epi-Pen Care Plan. You can find these forms at www.skyranchcolorado.org/forms.

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. On page 2 of this form, please indicate which medications should not be administered to the participant by crossing them out.

HEALTH HISTORY

DIETARY NEEDS: *Please select all options that apply.*

- ☐ Vegetarian
- ☐ Vegan
- ☐ Gluten Free
- ☐ Nut Free
- ☐ Lactose Free

Is it okay to have milk baked into foods? ☐ YES ☐ NO

- ☐ I have Celiac disease.
- ☐ Cross-contamination is a concern.
- ☐ This need is a dietary choice/preference.
- ☐ There are no worries regarding cross-contamination.
- ☐ Other: _____

Please explain each each checked item and include any additional information that will assist Sky Ranch in caring for your child:

_____

_____

MENTAL/EMOTIONAL HEALTH

- ☐ Anxiety
- ☐ Depression
- ☐ ADD/ADHD
- ☐ Autism Spectrum Disorder
- ☐ Bipolar Disorder
- ☐ Eating Disorder
- ☐ Other: _____

Please explain each item checked and share any additional information that may assist Sky Ranch in caring for your child.

_____

_____

_____

_____

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HEALTH HISTORY - CONTINUED

CHRONIC CONCERNS:

- ☐ Seizures/Convulsions
- ☐ Mononucleosis
- ☐ Fainting/Dizzy Spells
- ☐ Head Injury
- ☐ Sleepwalking
- ☐ Frequent Headaches
- ☐ Diabetes
- ☐ Heart Disease/Defect
- ☐ Asthma
  Required to complete Asthma Care Plan*
- ☐ High Blood Pressure
- ☐ Frequent Ear Infections
- ☐ Cancer
- ☐ Head Injury
- ☐ Bleeding/Clotting Disorder
- ☐ Painful Menstrual Cycle
- ☐ Kidney Disease
- ☐ Developmental Delays
- ☐ Learning Disability
- ☐ Bedwetting
- ☐ Digestive Issues

ALLERGIES:

☐ Insect ☐ Food ☐ Medication ☐ Other: _____

Please describe allergen, reaction, and treatment. Attach more information as needed.

_____

_____

_____

****If camper carries an EpiPen, it is required to fill out the EpiPen Action Plan.****

☐ Other: _____

_____

_____

Please explain each item checked in the lines provided:

_____

_____

_____

Is there any additional medical information we should be aware of regarding your camper?

_____

_____

_____

STOCKED OVER THE COUNTER MEDICATIONS

The medications listed below are available in the nurses' cabin at Sky Ranch Lutheran Camp. Our health care supervisor is responsible for administering these medications.

Please indicate any medications that SHOULD NOT BE ADMINISTERED to your camper by crossing them off.

Acetaminophen/Tylenol
Acetaminophen (<18 y.o.)
Alcohol Wipes
Aloe Vera
Anbesol
Ammonia Inhalants
Antacids/Tums
Aquaphor
Antibiotic Ointment
Biofreeze
Bug Spray
BZK Wipes
Calamine Lotion
Campho-Phenique
Cetirizine/Zyrtec
Claritin
Cough Drops
Cough Syrup
Dimenhydrinate/Dramamine
Emergen-C
Excedrin
Gold Bond Powder
Hydrocortisone Cream
Ibuprofen/Advil
Imodium
Insta-Glucose
Diphen-Benadryl
Saline Eye Wash
Sunscreen
Pseudoephedrine/Sudafed
Midol
Melatonin
Naproxen/Aleve

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Last Name: _____ First Name: _____

MEDICATIONS

TO BE COMPLETED BY HEALTHCARE PROVIDER: Please fill out the form with a complete list of all medications (prescription, over-the-counter, and vitamins) that you will be bringing to camp. Ensure that all medications are in their original containers when brought to camp.

Will your child be taking any medications while at camp? ☐ YES ☐ NO

MEDICATION 1:
Medication Name (as written on the bottle): _____ **Dosage:** _____ (mg/ml & tab/capsule)
Administration Time: ☐ As Needed ☐ AM ☐ PM ☐ Taken with Food ☐ Other: _____
Purpose for Administration: _____

MEDICATION 2:
Medication Name (as written on the bottle): _____ **Dosage:** _____ (mg/ml & tab/capsule)
Administration Time: ☐ As Needed ☐ AM ☐ PM ☐ Taken with Food ☐ Other: _____
Purpose for Administration: _____

MEDICATION 3:
Medication Name (as written on the bottle): _____ **Dosage:** _____ (mg/ml & tab/capsule)
Administration Time: ☐ As Needed ☐ AM ☐ PM ☐ Taken with Food ☐ Other: _____
Purpose for Administration: _____

MEDICATION 4:
Medication Name (as written on the bottle): _____ **Dosage:** _____ (mg/ml & tab/capsule)
Administration Time: ☐ As Needed ☐ AM ☐ PM ☐ Taken with Food ☐ Other: _____
Purpose for Administration: _____

MEDICATION 5:
Medication Name (as written on the bottle): _____ **Dosage:** _____ (mg/ml & tab/capsule)
Administration Time: ☐ As Needed ☐ AM ☐ PM ☐ Taken with Food ☐ Other: _____
Purpose for Administration: _____

All medications must be brought in their original containers with prescription label attached.

If your camper requires more medications than what can be listed on this form, please print an extra copy of this page and continue to provide their medication details. It is required that this information is submitted using this form.

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Last Name: First Name:

Parent/guardian Name:
(If camper is under 18 years of age) Birth Date:

IMMUNIZATIONS

TO BE REVIEWED BY HEALTHCARE PROVIDER:

In accordance with our child care licensing regulations, it is essential that the immunization records for your camper are filled out on this specific form. If your records are provided in a different format or on another document, please transfer the information to this form before submitting it to the camp.

COLORADO CERTIFICATE OF IMMUNIZATION

cdphe.colorado.gov/immunization

COLORADO
Department of Public Health & Environment

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 if disease		**Varicella** - positive screen date	

Recommended Vaccines

	Immunization date(s) MM/DD/YY						
HPV Human Papillomavirus							
RV Rotavirus							
MCV4 Meningococcal							
MenB Meningococcal							
HepA Hepatitis A							
Flu Influenza							
COVID-19							
Other							

Please provide any Immunization Exemptions, Asthma Care Plans, or Epi-Pen Action Plans if applicable.
If you have any questions, don't hesitate to call our office at (970) 493-5258.

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Last Name: _____ First Name: _____

PARENTAL/GUARDIAN AND HEALTHCARE PROVIDER AUTHORIZATION

PARENTAL/GUARDIAN RELEASE

REQUIRED TO ATTEND CAMP

I give my approval for the use of the over-the-counter medications listed on page 2 for the participant as needed. I have indicated any medications that are not approved for the participant by crossing them off. I authorize and give my permission to the healthcare supervisor at Sky Ranch Lutheran Camp to administer medication to the participant named above. I understand that all medications must be provided in their original pharmacy-labeled containers. I acknowledge that my child is responsible for visiting the nurse at the designated times to receive their medications. I hereby give my permission for Sky Ranch Lutheran Camp to provide care to the camper in the event of illness or injury and understand that they will make an effort to contact me in such situations. I authorize Sky Ranch Lutheran Camp and its staff to seek medical treatment and procedures for the participant as necessary in emergency circumstances, which may include care from physicians, hospital and clinic personnel, and other qualified healthcare providers.

X _____ _____

Signature of Parent/Guardian ***Signature is required in order to attend camp*** **Date**

All campers, including those aged 18 and older, must provide this signature.

HEALTHCARE PROVIDER RELEASE (NP, PA, MD, DO)

REQUIRED TO ATTEND CAMP

- I reviewed and approve the medications and dosages specified above for the camper identified above.
- I reviewed and approve the over-the-counter medications listed to be at Sky Ranch for use as needed by this camper.
- I have examined this camper within the past 24 months and reviewed their health history. In my opinion, this camper is in satisfactory health and capable of engaging in all camp activities, unless noted otherwise.
- I have completed and reviewed the immunization record.

X _____ _____

Signature of Healthcare Provider ***Signature is required in order to attend camp*** **Date**

Please print Healthcare Provider's Name: _____ Provider Phone Number: _____

Provider Address: _____

Anything Else You Would Like Camp to Know About Your Camper:

SUBMIT TO CAMP AT: **EMAIL:** office@skyranchcolorado.org **OR FAX:** (970) 493-7960
OR UPLOAD to your campers Campwise Registration Account