FORM 5

# *Emergency Information Form – Adults at Camp de Benneville Pines*

Name _____ DOB _____

Address _____ City _____ ST _____ Zip _____

Home Phone# _____ Cell Phone# _____

Medical Insurance Company _____ Phone# _____

Policy# _____ Group# _____

Emergency Contact (not at camp)

Name _____ Phone#1 _____

Phone#2 _____ Email/SMS _____

My immunizations are up-to-date YES NO Date of last tetanusshot _____

**Known allergies to food, medication and/or anesthetics, environmental factors** (use other side for additional information)**:**

_____

**Known medical problems/conditions and medical treatment that may be needed at camp** (use other side for additional information)**:**

_____

**Please list all medications; OTC & RX that you will be taking while at camp** (use other side for additional information)**:**

_____

I understand that if I become injured or ill while at camp, the Health Supervisor is authorized to determine if I require care outside the bounds of that available in our wilderness setting. Due to de Benneville's isolation and elevation, any camper remaining ill for more than 12 hours may be asked to leave camp, and may return only with authorization from a physician. I have been made aware that it can take 45 minutes or more for paramedics to respond to a 911 emergency call. If road conditions are icy or hazardous, it can take substantially longer. I agree to follow the safety rules of the camp.

This form is for use by the Health Supervisor during camp only. After camp, it will be shredded. We do not retain medical records for adult campers.

Option 1

I hereby give permission for the camp first aid person to provide routine health care and emergency medical treatment, including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. I give permission to the retreat organizers or the camp staff to arrange necessary related transportation. In the event of an emergency, I hereby give permission to the physician selected by the retreat organizers or camp staff to secure and administer treatment, including hospitalization.

Signature of Adult Camper/Participant _____ Date _____

Option 2

Although I understand that my medical information is being requested only so that medical treatment can be provided in case of an emergency, loss of consciousness or inability to make a decision on my own, and that not having this information may make it impossible for the Health Supervisor to provide appropriate medical care, I wish to decline to provide the requested medical information.

Signature of Adult Camper/Participant _____ Date _____

**Medications being taken**

Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage and the frequency of administration.

Circle one: the camper ***takes NO medications*** on a routine basis the camper ***takes medications*** as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Attach additional pages for more medications

**General Questions** (explain "yes" answers below)

| | | | | | |
|---|---|---|---|---|---|
| 1 | Had any recent injury, illness or infectious disease? | Y / N | 16 | Ever had a back problem? | Y / N |
| 2 | Have a chronic or recurring illness/condition? | Y / N | 17 | Ever had problems with joints (e.g. knees, ankles)? | Y / N |
| 3 | Ever been hospitalized? | Y / N | 18 | Have an orthotic appliance being brought to camp? | Y / N |
| 4 | Ever had surgery? | Y / N | 19 | Have any skin problems (e.g. itching, rash, acne)? | Y / N |
| 5 | Have frequent headaches? | Y / N | 20 | Have diabetes? | Y / N |
| 6 | Ever had a head injury? | Y / N | 21 | Have asthma? | Y / N |
| 7 | Ever been knocked unconscious? | Y / N | 22 | Had mononucleosis in the past 12 months? | Y / N |
| 8 | Wear glasses, contacts, or protective eyewear? | Y / N | 23 | Had problems with diarrhea/constipation? | Y / N |
| 9 | Ever had frequent ear infections? | Y / N | 24 | Have problems with sleepwalking? | Y / N |
| 10 | Ever passed out during or after exercise? | Y / N | 25 | If female, have an abnormal menstrual history? | Y / N |
| 11 | Ever been dizzy during or after exercise? | Y / N | 26 | Have a history of bed-wetting? | Y / N |
| 12 | Ever had seizures? | Y / N | 27 | Ever had an eating disorder? | Y / N |
| 13 | Ever had chest pain during or after exercise? | Y / N | 28 | Waived or missed any scheduled immunizations? | Y / N |
| 14 | Ever had high blood pressure? | Y / N | 29 | Ever had emotional difficulties for which professional help was sought? | Y / N |
| 15 | Ever been diagnosed with a heart murmur? | Y / N | | | |

Please explain any "yes" answers, noting the number of the questions: _____

_____

Name of family physician _____ Phone _____

Name of family dentist/orthodontist _____ Phone _____

Use this space to provide any additional information you believe the camp staff should be aware of regarding the campers behavior and physical, emotional, or mental health: _____

_____

## Authorization to Treat During Transportation/Carpooling to Camp

**Permission Form:**

My child/ward has permission to travel to and from Camp de Benneville Pines near Angelus Oaks, California. I understand that the camp is not responsible for the safety of my child until my child has been properly checked in at the time of registration. Furthermore, once my child checks out of camp on the final day, the camp is no longer responsible for the safety of my child. Unless otherwise contacted by me, my child has permission to carpool to and from camp with the following adults (***please include names of all adults permitted to pick your child up from camp, including parents***):

Name_____ Home Phone _____ Cell Phone_____

Name_____ Home Phone _____ Cell Phone_____

Name_____ Home Phone _____ Cell Phone_____

Name_____ Home Phone _____ Cell Phone_____

**Emergency Authorization to Treat:**

I hereby give permission to the medical personnel selected by my child/ward's driver to order x-rays, routine tests and treatment for my child/ward; and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the driver of my child/ward to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child/ward named above. This form may be photocopied. I recognize that neither de Benneville Pines, Inc., nor the Pacific Southwest District of the Unitarian Universalist Association is responsible for persons car pooling to or from camp.

Signature of parent/guardian _____ Date _____

*During the times my child will be transported to and from camp, you should be able to reach me:*

To Camp - Phone _____ Alternate Phone _____

From Camp - Phone _____ Alternate Phone _____