CAMP KATERI TEKAKWITHA 2024

All Camps are Held at: PRAIRIE STAR RANCH 1124 California Road, Williamsburg, KS 66095

CAMPER HEALTH INFORMATION

BRING FORM TO CAMP
DO NOT MAIL

CAMPER NAME: _____

CAMPER ADDRESS: _____

CAMP SESSION NAME/#/DATE: _____

CAMPER GRADE IN FALL 2024: _____ **AGE:** _____ **DOB:** _____

Are all immunizations up to date: Yes____ No____. **If not, explain** _____.

Date of Last Tetanus Booster: _____ **(Tetanus Boosters are required every 10 years).**

The camper named above is physically fit to attend camp at Camp Kateri Tekakwitha and participate in camp activities. The date of last exam was _____ (within the past 24 months). Please list current ongoing treatments or medications, and any restrictions on camp activities if any

_____

_____.

Camp Activities include but are not limited to horseback riding, high ropes challenge, canoeing, hiking, orienteering, rock climbing, rappelling, basketball, soccer, swimming, group party games, archery, volleyball, mountain biking, mountain boarding, camping, softball, numerous Catholic prayer and sacramental experiences, and other outdoor camp activities. Not all activities will be available for 5th & 6th grade campers. No camper will be forced to participate in any activity in which they are uncomfortable.

MEDICAL HISTORY: Please list (on a separate page, if necessary):

1. Any operations or serious injury in the past two years.
2. Medical limitations or needs that we need to be aware of.
3. Any limitations or needs (learning styles, family situations, custody arrangements, etc.).

_____

_____

_____

Licensed Physician Name: _____

Address: _____

Phone Number: _____

_____

Physician Signature **Date**

Illnesses and Treatment: Please notify the Camp Director if the child named above is exposed to any communicable disease, including but not limited to Covid-19, during the three weeks prior to camp. Parents will be notified of fever, vomiting, intense homesickness or anxiety, areas that require gauze bandaging, x-rays or stitching, and of other situations of concern to determine the course of action to be taken. In case of medical emergency, I understand that every effort will be made to contact parents or guardians of camper. In the event that I cannot be reached, I hereby request and give permission to the physician selected by the Camp to hospitalize, secure proper treatment for, and to order anesthesia or surgery for my child. In signing this health form, I hereby certify that the information contained herein is correct and give permission for the release of medical records to an attending physician in case of illness or emergency. I request that my child be transported if necessary to seek needed medical attention. I understand that I will be responsible for any medical and related expenses for my child.

Parent Name: _____

Address: _____

Phone #s: _____

_____

Parent or Guardian Date

Emergency Contact Name: _____
Phone #s: _____
Relationship: _____ _____
Parent or Guardian Date

Emergency Contact Name: _____
Phone #s: _____
Relationship: _____ _____
Parent or Guardian Date

HEALTH INSURANCE/LIABILITY INFORMATION

INSURANCE / LIABILITY INFORMATION:

Health Insurance Company:

_____

Health Insurance Policy #:

_____

Primary Health Insurance Holder Name:

_____

A Photocopy of the Primary Health Insurance card MUST be submitted with this form. Please copy the front and back of the card.

ASSESSING THE HEALTH STATUS OF YOUR CAMPER

If you check "yes" for any of these, please speak with the Nurse before proceeding during registration.

Has the camper had any of the following in the past 7 days?

1. Fever (100°F or greater)? …… ☐ Yes ☐ No
2. Sore throat? …….. ☐ Yes ☐ No
3. Cough? …….. ☐ Yes ☐ No
4. Exposed to a communicable disease? …… ☐ Yes ☐ No
5. Diagnosis of any illness? ……... ☐ Yes ☐ No
6. Been exposed to or had head lice? …….. ☐ Yes ☐ No

ALLERGIES/CONDITIONS

ALLERGIES/CONDITIONS: Check if participant is allergic to any listed or has any of the following conditions:

_____ Bee Stings	_____ Poison Ivy	_____ Asthma
_____ Penicillin	_____ Sulfa	_____ Seizures
_____ Latex	_____ First Aid Antiseptics	_____ Antibiotics
_____ Fainting	_____ Hay Fever	_____ Other

Special Dietary Needs or Food Allergies: (Circle One) YES NO

If YES, please submit a statement in space provided below of how the child has been treated and with what medications.

THIS FORM SHOULD BE BROUGHT TO CAMP ON OPENING DAY (DO NOT MAIL)

(A signed physical form, not more than *24 months old*, can be attached to this form in place of obtaining the physician's signature in the medical section. The form must be complete otherwise and signed by parent and turned in at check in).