

# CAMP KATERI TEKAKWITHA 2026

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

## CAMPER HEALTH INFORMATION

Bring Forms to Camp  
DO NOT MAIL

**CAMPER NAME:** \_\_\_\_\_

**CAMPER ADDRESS:** \_\_\_\_\_

**CAMP SESSION NAME /#/ DATE:** \_\_\_\_\_

**CAMPER GRADE IN FALL 2026:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

All immunizations required for school are up to date: Yes \_\_\_\_\_ No \_\_\_\_\_ If not, explain \_\_\_\_\_

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 5<sup>th</sup> & 6<sup>th</sup> 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:

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Health Insurance Policy #:

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Primary Health Insurance Holder Name:

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**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)? .....
2. Sore throat? .....
3. Cough? .....
4. Exposed to a communicable disease? .....
5. Diagnosis of any illness? .....
6. Been exposed to or had head lice? .....

Yes  No

Yes  No

Yes  No

Yes  No

Yes  No

Yes  No

## ALLERGIES/CONDITIONS

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

<input type="checkbox"/> Bee Stings	<input type="checkbox"/> Poison Ivy	<input type="checkbox"/> Asthma
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Seizures
<input type="checkbox"/> Latex	<input type="checkbox"/> First Aid Antiseptics	<input type="checkbox"/> Antibiotics
<input type="checkbox"/> Fainting	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> 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).