SUN VALLEY TREKKING MEDICAL STATEMENT
CAMP GIMLET

Camper Information:

____

Last Name First Name Middle Initial

____

Address City State Zip Cell Telephone Number

( ) Male ( ) Female ____

Date of Birth Age on arrival to camp

Emergency Contact:

____

Name Relationship to camper Telephone

I am not aware of, and am not under treatment for any physical infirmity or chronic ailment or injury which would affect my ability to participate in the Sun Valley Trekking activity I have reserved. Further, I have, or have not, as checked, had symptoms of or been treated for the following:

Yes( ) No( ) Cardiac or pulmonary condition or disease
Yes( ) No( ) High or low blood pressure
Yes( ) No( ) Fainting spells/convulsions/epilepsy
Yes( ) No( ) Sleep Problems/ Sleepwalking
Yes( ) No( ) History of bedwetting
Yes( ) No( ) Severe allergic reactions
Yes( ) No( ) Kidney or related diseases
Yes( ) No( ) Any Respiratory problem
Yes( ) No( ) Diabetes
Yes( ) No( ) Back Injury
Yes( ) No( ) Been Hospitalized
Yes( ) No( ) Wears corrective lenses
Yes( ) No( ) Any Orthopedic problems
Yes( ) No( ) Knee or Ankle injuries
Yes( ) No( ) Recent injury or surgery

If you have answered 'yes' to any of the above conditions, please describe (use back of sheet if more space required)

____
____
____

Allergies: ( ) No Known Allergies
( ) This camper is allergic to ( ) Food ( ) Medicine ( ) Environmental ( ) other
(Please describe below what the camper is allergic to and the reaction seen.)

____
____
____

Diet, Nutrition: ( ) this camper eats a regular diet ( ) this camper eats a vegetarian diet
( ) This camper has special food needs (Please describe below)

____
____

Medication: ( ) This camper will not take daily medications while at camp.
( ) This camper will take the following daily medication(s) while at camp.

Name of Medication	Reason for taking it	When is it given	Amount or dose given
		( ) Breakfast ( ) Lunch ( ) Dinner ( ) Bedtime	
		( ) Breakfast ( ) Lunch ( ) Dinner ( ) Bedtime	

The following non-prescription medications may be stocked at Camp and are used on an as needed basis to manage illness or injury,
Cross out those the camper should NOT be given.

Acetaminophen (Tylenol)
Antihistamine/ allergy medicine
Diphenhydramine antihistamine (Benadryl)
Calamine lotion
Aloe

Ibuprofen (Advil, Motrin)
Guaifenesin cough syrup (Robitussin)
Generic cough drops
Antibiotic cream

What have we forgotten to ask?

Please provide in the space below any additional information about the camper's health that you think important that may affect the camper's ability to fully participate in the camp program.

Medical Insurance Information:

This camper is covered by family medical/hospital insurance ( ) Yes ( ) No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company____

Policy # ____

Subscriber ____

Insurance Company Phone # (________)_________________________

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

I HEREBY CERTIFY AND WARRANT THAT THE STATEMENTS CONTAINED ABOVE ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. I FURTHER CERTIFY AND UNDERSTAND THAT ACCEPTANCE OF THIS STATEMENT BY SUN VALLEY TREKKING CO. WILL BE MADE ON THE BASIS OF THE STATEMENTS CONTAINED ABOVE, AND SUCH ACCEPTED STATEMENT WILL BECOME PART OF THE AGREEMENT BETWEEN MYSELF AND SUN VALLEY TREKKING TO PROVIDE THE TREK/ CAMP SERVICES.

Custodial Parent/ Guardian
(Please Print & Sign)____

Date_________________ Relationship to Camper____________________________________