PILGRIM LODGE JUMP START WORK DAY – YOUTH GROUP OVERNIGHT PERMISSION SLIP

Please bring this form as well as the completed health form 1.

I, ___________________________________ as parent or legal guardian give my permission for

____to participate in (check all that apply):

____ **Friday night** overnight at Jump Start Weekend, on (date)___________ This part of the weekend is under the supervision of the youth group from (church and town) _______________________________

I understand that the youth group leader _______________________________ is in charge of

supervision of my child during the overnight event.

_____ **Saturday Jump Start Work Day** at Pilgrim Lodge, (date)___________. I understand my child will be

working to open the summer camp and that there is some risk in doing manual labor.

____ **Saturday Youth Group Overnight at PL**. (date) _____________ This part of the weekend is under the supervision of the youth group from (church and town)

_________________________________ I understand that the youth group leader

_______________________________ is in charge of

supervision of my child during the overnight event.

Participant Release/Assumption of Risk Agreement/Agreement to Indemnify & Hold Harmless/Certification of Agreement: Each person signing below understands that participation in the Maine Conference of the United Church of Christ ("Maine Conference") program can involve the risk of damage and injury, including serious injury, to both people and property. Each person signing below understands and agrees that Maine Conference, its agents, officers and employees, accept no responsibility, and will not be liable, for any injury, harm or damage to his/her person or property (including, but not limited to, injury, harm or damage caused by negligence of Maine Conference, its agents, officers or employees) occurring during or arising out of participation in any Maine Conference program. To the fullest extent permitted by law, each person signing below agrees to assume all risk of injury, harm or damage to his/her person or property arising during or in connection with said Maine Conference program. Each person signing below hereby releases and agrees to indemnify and hold harmless Maine Conference, its agents, officers and employees, from any and all liability, actions, damages and claims of any kind and nature whatsoever for any injury, harm or damage to his/her person or property (including, but not limited to, injury, harm or damage caused by negligence of Maine Conference, its agents, officers or employees) that may arise or occur during or in connection with said program. Each person signing below has read through all the rules, regulations and policies contained in the Pilgrim Lodge parent and camper guide. Each person signing below further understands and agrees to abide by these rules, regulations and policies at all times. In addition, each person signing below is aware that a list of camper names and addresses is distributed to event participants at the end of camp (phone numbers are not included). Each person signing below permits the Maine Conference to use images of me or my child taken at Pilgrim Lodge or its camp trips in promotion of Maine Conference programs, including, but not limited to, future camp brochures, promotional slide shows, video presentations and the Pilgrim Lodge website. I give my permission for any medical personnel or institution to treat my child in the event of an emergency.

Signed_______________________________________Date__________________________________
(parent or guardian)

Pilgrim Lodge Camper Health History for CHILDREN, FORM 1

(page 1 of 3) To be completed by parents.
(Children also need form 2 to be completed by a licensed physician)
Developed and reviewed by *American Camp Association American Academy of Pediatrics Council on School Health & Association of Camp Nurses*

Mail at least two weeks prior to event to:

Pilgrim Lodge ~ Health Form
103 Pilgrim Lodge Lane
West Gardiner, ME 04345

Dates attending camp: from __________ to ____________

Camper Name: ____

☐ Male ☐ Female Date of Birth ___________________

To Parent(s)/Guardians(s): Attach additional information if needed.

1) Complete pages ***1, 2, & 3*** of this form (Form 1) and **make a copy**
2) Send the original, signed ***FORM 1*** to camp two weeks before arriving.
3) Complete the top of FORM 2 (Camper Health Care Recommendations) and provide the copy of FORM ! With FORM 2 to your child's health care provider for review and completion
4) If your child carries an **inhaler, epi-pen** or other medication on his or her person, fill out the bottom section of FORM 3, have the physician fill out the top section.
5) Return Form 2 (and if applicable FORM 3) completed and signed by your child's health-care provider, camp at least two weeks before arrival.

Camper Name ______________ (For Camp Use) Cabin ______

Camper Home Address: ____
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: ______________________ Relationship to Camper ______________ Preferred Phones (____) __________, (____) __________

Email: ______________________ Address: ______________________
(if different from above)

Second parent/guardian or other emergency contact:

Name: ______________________ Relationship to Camper ______________ Preferred Phones (____) __________, (____) __________

Email: ______________________ Address: ______________________
(if different from above)

Additional contact in the event parent(s) or guardian(s) cannot be reached

Name: ______________________ Relationship to Camper ______________ Preferred Phones (____) __________, (____) __________

Allergies: ☐No known **allergies** ☐This camper is allergic to: ☐ Food ☐ Medicine ☐Environmental agents
(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 regular vegetarian diet.
☐This camper has special food needs ***(Please describe below, continue on back if necessary)***

☐ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions
☐ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations
(Please describe, continue on back if necessary.)

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 Number ______________________

Subscriber ______________________ Insurance Co. Phone No. (______) ______________________

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.

Signature of Custodial Parent/Guardian ______________________ Date:______________ Relationship to Camper: ______________

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

CAMPER HEALTH HISTORY FORM 1	Camper Name: ____ First Middle Last
Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*	Birth Date: ____ Month/Day/Year

Immunization History: Provide the month and year for each immunization. Starred (★) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization		Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria, tetanus, pertussis★ (DTaP) or (TdaP)							
Tetanus booster★ (dT) or (TdaP)							
Mumps, measles, rubella★ (MMR)							
Polio★ (IPV)							
Haemophilus influenzae type B (HIB)							
Pneumococcal (PCV)							
Hepatitis B							
Hepatitis A							
Varicella (chicken pox)	☐Had chicken pox Date:						
Meningococcal meningitis (MCV4)							

Tuberculosis (TB) test	Date:	☐ Negative	☐ Positive

If your camper has not been fully immunized, please sign the following statement: **I understand and accept the risks to my child from not being fully immunized.**

Signature of Custodial Parent/Guardian: ____ Date: ____ Relationship to Camper: ____

Medication: ☐ This camper will not take any daily medications while attending camp.

☐ This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. ***Please review camp instructions about required packaging/containers. Many states require original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.***

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:____		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:____		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:____		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. ***Cross out those the camper should not be given.***

Acetaminophen (Tylenol)
Phenylephrine decongestant (Sudafed PE)
Antihistamine/allergy medicine
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Sore throat spray
Lice shampoo or cream (Nix or Elimite)
Calamine lotion
Laxatives for constipation (Ex-Lax)
Ibuprofen (Advil, Motrin)
Pseudoephedrine decongestant (Sudafed)
Guaifenesin cough syrup (Robitussin)
Dextromethorphan cough syrup (Robitussin DM)
Generic cough drops
Antibiotic cream
Aloe
Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

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CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: ____
First Middle Last

Birth Date: ___________
Month/Day/Year

General Health History: *Check "Yes" or "No" for each statement. Explain "Yes" answers below.*

Has/does the camper:

Question	Yes	No
1. Ever been hospitalized?	☐ Yes	☐ No
2. Ever had surgery?	☐ Yes	☐ No
3. Have recurrent/chronic illnesses?	☐ Yes	☐ No
4. Had a recent infectious disease?	☐ Yes	☐ No
5. Had a recent injury?	☐ Yes	☐ No
6. Had asthma/wheezing/shortness of breath?	☐ Yes	☐ No
7. Have diabetes?	☐ Yes	☐ No
8. Had seizures?	☐ Yes	☐ No
9. Had headaches?	☐ Yes	☐ No
10. Wear glasses, contacts, or protective eyewear?	☐ Yes	☐ No
11. Had fainting or dizziness?	☐ Yes	☐ No
12. Passed out/had chest pain during exercise?	☐ Yes	☐ No
13. Had mononucleosis ("mono") during the past 12 months?	☐ Yes	☐ No
14. If female, have problems with periods/menstruation?	☐ Yes	☐ No
15. Have problems with falling asleep/sleepwalking?	☐ Yes	☐ No
16. Ever had back/joint problems?	☐ Yes	☐ No
17. Have a history of bedwetting?	☐ Yes	☐ No
18. Have problems with diarrhea/constipation?	☐ Yes	☐ No
19. Have any skin problems?	☐ Yes	☐ No
20. Traveled outside the country in the past 9 months?	☐ Yes	☐ No

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

Mental, Emotional, and Social Health: *Check "Yes" or "No" for each statement.*

Has the camper:

Question	Yes	No
1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?	☐ Yes	☐ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?	☐ Yes	☐ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?	☐ Yes	☐ No
4. Had a significant life event that continues to affect the camper's life? (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)	☐ Yes	☐ No

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Health-Care Providers:

Name of camper's primary doctor(s): ______________________________ Phone: (________) ____________________

Name of dentist(s):______________________________ Phone: (________) ____________________

Name of orthodontist(s):______________________________ Phone: (________) ____________________

What Have We Forgotten to Ask? ***Please provide in the space below*** any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program***. Attach additional information if needed.***

Parents/Guardians: STOP here. The rest of this is form is completed when the camper arrives at camp. Keep a copy for your records.

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