Camp Rocky - OUTDOOR ENVIRONMENTAL ADVENTURES

Located at: Rocky Mountain Mennonite Camp

709 County Road 62
Divide, Colorado 80814

RMMC (719) 687-9506
CACD (719) 686-0020

The **CAMP ROCKY STAFF** has a sincere concern for the health and well being of each child enrolled. Every precaution is taken to ensure each camper's health and safety. The information and authorizations required below will help to provide prompt notification and proper care in case of emergency. **Please return these forms by June 15, 2020 to CACD, PO Box 1175 , Lamar, CO 81052**

2020 CAMPER HEALTH INFORMATION

To be completed by a licensed physician or licensed nurse practitioner within 24 months (2 years) of camp attendance.

CAMPER'S NAME: _____

HEALTH HISTORY	IMMUNIZATION RECORD
Past history of communicable diseases and/or serious illnesses, lacerations, injuries or surgeries:	List month and year each immunization listed below was given
	Diphtheria-Tetanus-Pertussis (DPT)
List any known drug reactions and allergies:	Tetanus-Diphtheria(TD)
	Polio
List any known food allergies:	Measles (Hard, Red)
	Rubella (German Measles)
Describe any special diets which the camper must follow:	Mumps
	Other

MEDICATIONS (List any prescriptive or non-prescriptive medications which camper must take:

NOTE: ALL MEDICATIONS (PRESCRIPTIVE OR NON-PRESCRIPTIVE) MUST BE PACKAGED, CLEARLY LABELED, AND DOSAGES EXPLAINED, TO BE HANDED OVER TO THE CAMP NURSE FOR ADMINISTRATION TO CAMPER.

Name of Medication	Dosage	Frequency	Prescribing Physician

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

I hereby authorize the properly qualified health supervisor of Rocky Mountain Mennonite Camp to administer the medication which has been prescribed for the camper listed above. The prescribed medication shall be from a licensed pharmacy, labeled with the name, address, and phone number of the pharmacy, name of the camper, name and strength of the medication, directions for use, date filled, prescription number and name of practitioner prescribing the medication.

Signature of Health Care Provider:	Title	Date

MEDICAL STATEMENT

I have examined this camper and found him/her to be in satisfactory physical condition and capable of active participation in a regular camp program, except as follows:

Signature of Health Care Provider			Title	Date
Office Address			Phone	
City	State	Zip	FAX	