MEDICAL FORM PART A 2023

For both Resident & Day Campers

(**This form must be completed by Parents/Guardians of Minors)**

NAME: _____
Last First Middle

DATE OF BIRTH: (M/D/Y) _____ AGE: ___ HEIGHT: ___ WEIGHT: ____

CONTACT INFORMATION

ADDRESS: _____
Street City State Zip Code Country

(____)_____
Home Phone (Area Code + #)

Father's Name: _____ Mother's Name: _____

Work Phone: (_____)_____ Work Phone: (_____)_____

Cell Phone: (_____)_____ Cell Phone: (_____)_____

E-mail: _____ E-mail: _____

Alternate Emergency Contact's Name 1: _____ Phone (____)_____

Alternate Emergency Contact's Name 2: _____ Phone (____)_____

Insurance Carrier: _____ Policy (____)_____

Under whose name is the insurance listed? _____ Group#_____

BASIC IMMUNIZATION HISTORY

HEALTH HISTORY

PLEASE ATTACH A COPY OF THE CAMPER'S INSURANCE CARD TO THIS MEDICAL FORM, SHOWING BOTH FRONT AND BACK SIDES OF THE CARD, AS WELL AS INFORMATION ABOUT SHOTS.
IF YOU HAVE MEDICAL INSURANCE, YOUR CARRIER WILL BE BILLED FOR YOUR MEDICAL CHARGES IN CASE OF ILLNESS OR INJURY WHILE YOUR CHILD IS AT CAMP.

Vaccines	**1st**	**2nd**	**3rd**	**4th**	**5th**	**6th**
DPT (Diphtheria, Pertussis, Tetanus)						
TD (Tetanus/ Diphtheria)						
OPV or IPV (Oral Polio Vaccine)						
MMR (Measles, Mumps, Rubella)						
TB Skin Test						
HIB – Hemophilus influenza B						
HEPATITIS A						
HEPATITIS B						

	Yes	No
Asthma		
Chicken Pox		
Diabetes		
Ear Infection		
Heart Problems		
Measles		
Mumps		
Hepatitis		

MEDICAL FORM PART B 2023

For both Resident & Day Campers

(**This form must be completed by Parents/Guardians of Minors**)

CAMPER'S NAME: _____

Last First Middle

RESTRICTIONS:

1. Dietary Restrictions/Food Allergies

   _____

2. Restriction of Camp Activities

   _____

HEALTH CARE RECOMMENDATION BY A LICENSED PHYSICIAN

1. Medical conditions under care of physician

   _____

2. Treatment needed during camp

   _____

3. Known Allergies

   _____

4. Medication to be administered:

Name of medication	**When to be taken?**	**Dosage**
_____	_____	_____
_____	_____	_____

ALL PRESCRIPTION MEDICATIONS MUST BE ACCOMPANIED BY PHYSICIANS' INSTRUCTIONS (ON LABEL OF MEDICATION OR BY SEPARATE, SIGNED, TYPEWRITTEN INSTRUCTIONS.)

5. Surgeries, serious injuries or fractures (when?)

   _____

6. Any behavioral problems or concerns we need to know.

   _____

FEMALE APPLICANTS: Has she menstruated? _____ If not, has she been told about it? ____

IMPORTANT: We regret that due to safety and hygiene issues, Camp Auxilium is unable to accommodate children who sleepwalk or wet the bed.

Request for Administration of Medications by Camp Personnel

CAMPER'S NAME:_____

Last First Middle

This health information is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted.

DATE OF BIRTH: (M/D/Y)_____ AGE:_____ Grade next year ____

In the event that my child suffers from any mild pain or discomfort, I allow that over-the-counter medication be administered to my child at the discretion of the staff of Camp Auxilium. I understand that if the pain or discomfort persists, the staff of Camp Auxilium will contact me regarding my child's condition.

1. Please list any over-the-counter medications that your child **cannot** take.

   _____

2. List any regular over-the-counter medications you give to your child.

   _____

I waive any and all claims for damages against the SALESIAN SISTERS and/or CAMP AUXILIUM and/or the Diocese of Monterey, which I may have or which may hereafter accrue to me or my child, as a result of the administering of medicine. I intend and agree to release and discharge in advance the SALESIAN SISTERS and/or CAMP AUXILIUM and/or the Diocese of Monterey, and its officers, agents and employees, from any and all liability relating to the administration of said medications.

_____ _____

Parent/Guardian Signature Date

(_____)_____ (_____)_____ (_____)_____

Home Number Work Number Cell Number

605 Enos Lane * Corralitos, CA * Phone (831) 728-5518 * Fax (831) 728-5802 *
www.salesianschool.org Email campauxiliumcalifornia@gmail.com

PARENT MEDICAL & LIABILITY RELEASE STATEMENT 2023

_____ RESIDENT CAMPER

_____ DAY CAMPER

Corralitos, CA
Camp Auxilium

CAMPER'S NAME: ____

Last **First** **Middle**

I understand that in the event that medical intervention is necessary, an attempt will be made to contact the persons listed on this form. If I cannot be reached in an emergency during the activity dates shown on this form, I give my permission to the physician or dentist selected by the camp administration to hospitalize, to secure medical treatment and/or order an injection, anesthesia, or surgery for my child as deemed necessary.

I understand that Camp Auxilium and its agents will take reasonable safety precautions during all Camp events and activities. I understand the possibility of unforeseen hazards and know there is the inherent possibility or risk. I agree not to hold Camp Auxilium and/or Salesian Sisters and/or the Diocese of Monterey, its leaders, employees and volunteers liable for damages, losses, diseases, or injuries incurred by the subject of this form. I hereby assume full responsibility for hospital bills, professional fees, and other medical expenses, other than those covered by the Camp accident insurance.

Parent/Guardian Signature ___________________________________Date ______________________

Signature of Camp attendee (if over 18) _______________________________Date ______________________

_ _

DECLARACION DE PADRES PARA EXONERAR RESPONSABILIDADES

Nombre del Asistente al Campamento:____

Yo entiendo que en el caso de que una intervención médica sea necesaria, se realizará un intento para contactar a las personas listadas en este formato. Si es que no puedo ser localizado en una emergencia durante las fechas de actividades mostradas en este formato, otorgo mi permiso a que un médico o dentista seleccionado por el líder de actividades hospitalice, proporcione tratamiento médico y/o aplique alguna inyección, anestesia o cirugía a mi hija(o) si es necesario.

Yo entiendo que Camp Auxilium y sus agentes tomarán las precauciones de seguridad razonables durante los eventos y actividades. Yo entiendo que existe la posibilidad de peligros imprevistos y sé que hay esa posibilidad inherente o riesgo. Yo acepto no hacer responsable a Camp Auxilium y/o Salesian Sisters y/o la Diócesis de Monterey, a sus líderes, empleados y voluntarios por daños, pérdidas, enfermedades o lesiones incurridas por el sujeto a esta forma. Por este medio asumo completa responsabilidad de gastos hospitalarios, honorarios profesionales y cualquier otro gasto médico que no sea cubierto por el seguro de accidentes del campamento.

Firma de Padre/Madre/Tutor: ____Fecha: _________________________

Firma de la Joven (si tiene más de 18 años) ___________________________Fecha:_________________________