

Camper Health Statement

This form is required by Colorado law and must be filled out and signed by camper's physician in order to attend camp.
To be completed by a licensed physician or qualified, licensed nurse practitioner (must be within the last 24 months of camp dates)

Camper Name _____ Date of Birth _____

Physical exam done today: Yes No (If "No," date of last physical) _____

This child is planning to attend a residential or trip camp, away from his/her home and probably distant from medical care. The camp must have a health supervisor who, at minimum, has completed an advanced first aid course. Your response to these questions will help in the care of this person.

Past history of serious lacerations, injuries, illnesses or communicable diseases: _____

Allergies or Drug Reactions: _____

Medication now being used by child and/or special dietary requirements: _____

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: _____

X Signature of PHYSICIAN or NURSE PRACTITIONER _____

Printed Name of PHYSICIAN or NURSE PRACTITIONER _____

Date _____ Address _____ Phone (____) _____

Immunization Record

Please attach Colorado Certificate of Immunization that has the month and year for the following vaccines:
Diphtheria-Tetanus-Pertussis (DTP or Baby Shots), Tetanus-Diphtheria (TD), Polio, Measles (Hard, Red), Rubella (German Measles), Mumps. Your camper registration is not complete without these records.

Authorization for Administration of Medications

I hereby authorize the properly qualified health supervisor of San Juan Bible Camp to administer medication which has been prescribed to the camper attending the above-named camp. 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 this medication, directions for use, date filled, prescription number, and name of practitioner prescribing the medication.

X Signature of PHYSICIAN or NURSE PRACTITIONER _____ Date _____



Mail to: San Juan Bible Camp
14260 Rd 39.9
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