

BEAVER CREEK YOUTH CAMP—CAMPER HEALTH HISTORY 2024—Part A

Camper's Name _____
 Date of Birth _____ Age on arrival at camp _____ Male Female
 Circle dates attending camp: June 3-July 2 July 7-12 July 14-19 July 21-26

Please return this completed form to:
 Beaver Creek Youth Camp
 P.O. Box 186
 South Fork, CO 81154
 Phone: (719) 873-5311
 Fax: (719) 873-0178
 manager@beavercreekcamp.org

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

1. Complete and sign part A of this form (on page 1 and 3).
2. Provide all three parts of this form to your child's primary health-care provider for review and completion of parts B and C.
4. After the provider has completed and signed parts B and C, you sign Part C, then copy and send all three parts of this form to Beaver Creek Youth Camp **at least two weeks before camp begins** (State law requires medical forms be in camp office at least 10 days before camp starts).

Please note: Colorado state law requires no children remain in camp without the proper medical and immunization records on file. Campers without the required records may be sent home.

Camper's Home Address: _____

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

Name: _____ Relationship to camper _____

Physical Address including city and zip: _____

Preferred Phone #s () () Email: _____

Second parent/guardian or other emergency contact:

Name: _____ Relationship to camper _____

Preferred Phone #s () () Email: _____

Additional contact in event parent(s)/guardian(s) can't be reached (Colorado law requires at least 3 emergency contacts.):

Name: _____ Relationship to camper _____

Preferred Phone #s () () Email: _____

Allergies: No known allergies

- Food—
- Medicine—
- Environment (insect stings, hay fever, etc.) —
- Other—

Diet, Nutrition: Regular diet Regular vegetarian diet Other, Please explain (if this is a medically prescribed diet, please include it on Part C of the Health History Form)—

Restrictions: I have reviewed the program and activities of the camp and feel my child can participate without restrictions.
 I have reviewed the program and activities of the camp and feel my child can participate with the following restrictions or adaptations—

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 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, 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 to the camp staff about my child's health status.

Signature of Custodial Parent/Guardian _____ **Date** _____ **Relationship to Camper:** _____

Camper's Name

Birth Date

Cabin

Revised 4/15/2024

CAMPER HEALTH HISTORY FORM—Part A

Camper's Name _____ Date of Birth _____

CAMPER'S INSURANCE INFORMATION

Insurance company _____ Phone # _____ Group or Plan Number _____

Address _____ City _____ State _____ Zip _____

Please attach a copy of the camper's insurance card.

If the camper is not covered by health insurance, please check here and read and sign the following statement:

My child is not covered by health insurance and I agree to pay my camper's health expenses . _____

Parent/Guardian Signature

Health-Care Providers:

Camper's primary doctor(s) _____ Phone (_____) _____

Camper's dentist _____ Phone (_____) _____

Camper's orthodontist _____ Phone (_____) _____

General Health History:

Has the camper:

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

Please note the question number and explain all yes answers below. Attach additional information if necessary.

CAMPER HEALTH HISTORY FORM—Part A

Camper's Name _____ Date of Birth _____

Mental, Emotional, and Social Health:

Has the camper:

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

Please note the question number and explain all yes answers below. Attach additional information if necessary

25. Have we missed anything? No Yes Please provide additional information, below, about the camper that may affect his or her ability to participate in camp programs.

Colorado State Child Care Regulations require Beaver Creek Youth Camp obtain "parent or guardian's written authorization and instructions for applying sunscreen to their children's exposed skin prior to outside play."

Beaver Creek Youth Camp will provide a high quality sunscreen with SPF 50 Broad Spectrum UVA/UVB Protection for campers to apply to themselves, under the supervision of camp staff, assuring that application and safety instructions for the sunscreen are followed.

By signing below, you indicate that you agree with this procedure.

Parent/Guardian Signature: _____ **Date:** _____

If you do not agree with this procedure, please call (719) 873-5311 to make other arrangements for sun exposure protection.

Beaver Creek Health History 2024 Part B
Particular Information Concerning Immunization Records

In previous years, Beaver Creek Youth Camp has accepted immunization records that were not on a “required form,” including records from other states and some in-state immunization documents.

During the 2021 camp season, Beaver Creek was found in violation of Colorado Department of Human Services, Office of Early Childhood, Division of Early Learning Licensing & Administration rule 7.711.31.E.

The camper must submit documentation of immunization status or exemption as required by Colorado Department of Public Health and Environment (CDPHE). Colorado law requires proof of immunization or exemption be provided prior to or on the first day of admission. Campers must submit documentation of immunization status or exemption on CDPHE’s required form.*

Beaver Creek appealed the violation, but the ruling was upheld.

At the time of the violation, the Colorado Department of Human Services, Office of Early Childhood, Division of Early Learning Licensing & Administration’s Licensing Specialist indicated to Beaver Creek’s manager that it is acceptable for a non-medical person, including a camper’s parent or guardian, to copy immunization records on to the Colorado Department of Public Health and Environment’s required form.

Therefore, Beaver Creek Youth Camp will only accept immunization records on the Colorado Department of Public Health and Environment’s required form. If a camper’s records are not on the required form, a parent or guardian should copy the records onto the required form included in the *Beaver Creek Camper Health History* packet, leaving the signature spaces blank.

If you have questions, please call (719) 588-7627.

***In 2022, the Colorado Department of Public Health and Environment (CDPHE) began accepting official immunization record forms from Alabama, Arizona, California, District of Columbia, Florida, Georgia, Illinois, Iowa, Kansas, Kentucky, Maryland, Montana, North Dakota, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Virginia, and Washington.**

Immunization records from all other forms must still be copied onto Colorado’s official form.

COLORADO CERTIFICATE OF IMMUNIZATION

cdphe.colorado.gov/immunization



COLORADO
Department of Public Health & Environment

This form is to be completed by a health care provider (physician [MD, DO], advanced practice nurse [APN] or delegated physician's assistant [PA]) or school health authority. School-required immunizations follow the Advisory Committee on Immunization Practices (ACIP) schedule. If the student provides an immunization record in any other format apart from this Certificate or an Approved Alternate Certificate (details found at cdphe.colorado.gov/immunization/forms), the school health authority must transcribe the record onto this form. Note: Final doses of DTaP, IPV, MMR and Varicella are required prior to kindergarten entry. Tdap is required at sixth grade entry.

Student Name: _____ Date of birth: _____

Parent/guardian:(if student is under 18 years of age and not emancipated) _____

Required Vaccines

	Immunization date(s) MM/DD/YY	Titer Date* MM/DD/YY
HepB Hepatitis B		
DTaP Diphtheria, Tetanus, Pertussis (pediatric)†		
Tdap Tetanus, Diphtheria, Pertussis‡		
Td Tetanus, Diphtheria		
Hib Haemophilus influenzae type b		
IPV/OPV Polio		
PCV Pneumococcal Conjugate		
MMR Measles, Mumps, Rubella ‡		
Measles		
Mumps		
Rubella		
Varicella Chickenpox		
Varicella - date of disease		Varicella - positive screen date

*The shaded area under "Titer Date" indicates that a titer is not acceptable proof of immunity for this vaccine.

In several instances, laboratory confirmation of positive titers are an acceptable alternative to written documentation of vaccination. A positive laboratory titer report must be provided to the school to document immunity. More information on titers can be found within the Colorado Board of Health rule 6 CCR 1009-2.
 † For DTaP and Tdap, both the diphtheria and tetanus titers must be positive. A titer is never acceptable to demonstrate immunity to pertussis.
 ‡ Laboratory confirmation of positive titers are an acceptable alternative to the MMR vaccine only when titers for all three components (measles, mumps, and rubella) are positive.

Recommended Vaccines

	Immunization date(s) MM/DD/YY
HPV Human Papillomavirus	
RV Rotavirus	
MCV4 Meningococcal	
MenB Meningococcal	
HepA Hepatitis A	
Flu Influenza	
COVID-19	
Other	

Health care provider printed name/signature: _____ / _____ Date: _____

Student is current on required immunizations for age (circle one): OR Yes No
 Immunization record transcribed/reviewed by school health authority: _____

School health authority signature or stamp: _____ Date: _____

(Optional) I authorize my/my student's school to share my/my student's immunization records with state/local public health agencies and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Parent/Guardian/Student (emancipated or over 18 yrs old) signature: _____ Date: _____

Medical Personnel: After reviewing parts A and B of this form, please complete part C (this and next page) and review it with the camper’s parent/guardian. Please attach additional information if needed. **Both a medical professional and a parent/guardian must sign this form.**

Camper’s Name _____ Date of Birth _____ <input type="radio"/> Male <input type="radio"/> Female													
Age on arrival at camp _____ Camper’s Home address _____													
Camp Session <input type="radio"/> 1st, 2nd 3rd Grade/Family/Grand July 5-7) <input type="radio"/> 4th, 5th & 6th Grade July 9-14 <input type="radio"/> 7th & 8th Grade July 16-21													
Physical exam done today? <input type="radio"/> Yes <input type="radio"/> No _____ Date of Last Exam Colorado state law requires that <i>the camper shall present a statement confirming a physical examination which has been preformed within the preceding twenty-four months by a licensed</i>	Diet & Nutrition: <input type="radio"/> Regular diet. <input type="radio"/> Lactose intolerant <input type="radio"/> Gluten intolerant <input type="radio"/> Other Medically prescribed meal plan or dietary restrictions—												
Weight: _____ lbs Height: _____ ft _____ in Blood Pressure ____/____	Is the camper undergoing treatment for any conditions at this time? <input type="radio"/> No <input type="radio"/> Yes—												
Allergies: <input type="radio"/> No known allergies <input type="radio"/> Foods <input type="radio"/> Medications <input type="radio"/> Environment (insects, hey fever, etc.) <input type="radio"/> Other	Are there treatments or therapies to be continued at camp? <input type="radio"/> No <input type="radio"/> Yes—												
Limitations or restrictions to activity whole at camp? <input type="radio"/> No <input type="radio"/> Yes—	These medications may be stocked in our camp’s health center and may be used to manage illness and/or injury of this individual. Please CROSS OUT those that should not be given to this individual. <table style="width:100%; border: none;"> <tr> <td>Acetaminophen (Tylenol)</td> <td>Aloe (topical)</td> <td>Calamine Lotion</td> </tr> <tr> <td>Couth Drops (menthol)</td> <td>Diphenhydramine (Benadryl)</td> <td>Tums</td> </tr> <tr> <td>Hydrocortisone Cream</td> <td>Ibuprofen (Advil, Motrin)</td> <td>Ivy Dry (contains benzyl alcohol, camphor, menthol)</td> </tr> <tr> <td>Laxatives</td> <td>Nix or Elimite</td> <td>Pseudoephedrine (Sudafed)</td> </tr> </table>	Acetaminophen (Tylenol)	Aloe (topical)	Calamine Lotion	Couth Drops (menthol)	Diphenhydramine (Benadryl)	Tums	Hydrocortisone Cream	Ibuprofen (Advil, Motrin)	Ivy Dry (contains benzyl alcohol, camphor, menthol)	Laxatives	Nix or Elimite	Pseudoephedrine (Sudafed)
Acetaminophen (Tylenol)	Aloe (topical)	Calamine Lotion											
Couth Drops (menthol)	Diphenhydramine (Benadryl)	Tums											
Hydrocortisone Cream	Ibuprofen (Advil, Motrin)	Ivy Dry (contains benzyl alcohol, camphor, menthol)											
Laxatives	Nix or Elimite	Pseudoephedrine (Sudafed)											

Please complete the medication information on the next page of this form!

Signature of Physician or Qualified Medical Professional:

I have reviewed parts A & B of this form, and have discussed the camp program with the camper’s parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program except as noted above.

I also issue standing orders for Beaver Creek Youth Camp’s properly trained and certified medical personnel to administer the over the counter and prescribed medications listed on this form to this camper.

Printed name of licensed provider: _____ Signature _____ Date _____

Office address _____ Phone _____

Parent/Guardian Signature:

I have review, with a qualified medical professional, the information on this form and agree that the information and instructions,

Medication: “Medication” is any substance a person takes to maintain and/or improve health. This includes vitamins, food supplements, and natural remedies. By Colorado state law, **all medications (prescription and over the counter) must be in the original pharmacy (or manufacturer) containers with labels.** Prescription medications must show the camper’s name and how the medication should be given. All medications (except inhalers & EpiPens®) must be turned into the camp medical center and will be dispensed from there. **Provide enough of each medication to last the entire time the camper will be at camp. Please confirm that the medications have not expired.**

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

This camper will take the following medication(s) while at camp.

Name of Medication	Date started	Reason for taking	When it is given	Amount or dose	How is it given
			<input type="radio"/> Breakfast <input type="radio"/> Lunch <input type="radio"/> Dinner <input type="radio"/> Bedtime <input type="radio"/> Other time _____		
			<input type="radio"/> Breakfast <input type="radio"/> Lunch <input type="radio"/> Dinner <input type="radio"/> Bedtime <input type="radio"/> Other time _____		
			<input type="radio"/> Breakfast <input type="radio"/> Lunch <input type="radio"/> Dinner <input type="radio"/> Bedtime <input type="radio"/> Other time _____		
			<input type="radio"/> Breakfast <input type="radio"/> Lunch <input type="radio"/> Dinner <input type="radio"/> Bedtime <input type="radio"/> Other time _____		

Emergency Inhaler/Epinephrine Pen Authorization: Emergency inhalers or epinephrine pen® may be carried by minors with **both physician’s and parent/guardian’s authorization.** Camper should bring at least one extra inhaler/epinephrine pen to be carried by a Beaver Creek staff member as a back up. *I hereby authorize the above named participant to carry his/her prescribed emergency inhaler and/or epinephrine pen on his/her own person while attending Beaver Creek Youth Camp:*

Parent/Guardian Signature: Sign here only if the above statement applies. **Date:** _____

Physician Signature: Sign here only if the above statement applies. **Date:** _____

Note: If the camper has medications prescribed by more than one healthcare provider, please call (719) 588-7627 before sending this form to Beaver Creek!