BEAVER CREEK YOUTH CAMP—CAMPER HEALTH HISTORY 2026—Part A

Camper's Name _____

Date of Birth _____ Age on arrival at camp _____ ◯ Male ◯ Female

Circle camp dates: 1st-3rd July 9-11 4th-6th July 13-18 7th-8th July 20-25 HS July 27-Aug. 1

Please return this completed form to:
Beaver Creek Youth Camp
P.O. Box 186
South Fork, CO 81154

Complete, signed forms may be scanned as PDF and emailed to manager@beavercreekcamp.org
Do not send pictures taken with a phone!

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 the camp office at least 10 days before camp starts).** **Do not text or email pictures taken with a phone!** Keep a copy for your records.

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 1/31/2026

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?..... ◯ Yes ◯ No
2. Ever had surgery?..... ◯ Yes ◯ No
3. Have recurrent/chronic illness? ◯ 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, protective wear?..... ◯ 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/sleep walking?..... ◯ 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 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 2026 Part B

IMMUNIZATION REQUIREMENTS TO ATTEND CAMP IN COLORADO

Please go to

https://cdphe.colorado.gov/immunization/requirements-to-attend-camp

to review the Colorado Department of Public Health & Environment (and Colorado Department of Early Childhood) immunization requirements for children and youth to attend camp in Colorado.

If you have questions, please contact your camper's health care provider or call (719) 588-7627.

Children and youth without up to date immunization records or a Colorado Certificate of Medical Exemption or a Colorado Certificate of Nonmedical Exemption may not attend Beaver Creek Youth Camp.

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 _____ ◯ Male ◯ Female

Age on arrival at camp _____ Camper's Home address _____

Camp Session ◯ 1st, 2nd & 3rd Grade July 9-11) ◯ 4th, 5th & 6th Grade July 13-18 ◯ 7th & 8th Grade July 20-25
◯ High School July 27-August 1

Physical exam done today?
◯ **Yes** ◯ **No**
Date of Last Exam _____
Colorado state law requires that *the camper shall present a statement confirming a physical examination which has been performed within the preceding twenty-four months by a licensed physician or qualified, licensed nurse practitioner.*

Weight: _____ lbs

Height: _____ ft _____ in

Blood Pressure _____/_____

Allergies: ◯ No known allergies
◯ Foods
◯ Medications
◯ Environment (insects, hey fever, etc.)
◯ Other

Diet & Nutrition: ◯ Regular diet. ◯ Lactose intolerant ◯ Gluten intolerant
◯ Other Medically prescribed meal plan or dietary restrictions—

Is the camper undergoing treatment for any conditions at this time? ◯ No
◯ Yes—

Are there treatments or therapies to be continued at camp? ◯ No
◯ Yes—

Limitations or restrictions to activity whole at camp? ◯ No
◯ 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.**

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)
Tolnaftate (Tinactin)	Topical Antibiotic Cream	Mylanta
Preservative-free Eye Drops	Chlorpheniramine maleate (Allegra)	

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 reviewed, with a qualified medical professional, the information on this form and agree that the information and instructions, etc. are correct.

Printed name of parent/guardian: _____ Signature _____Date _____

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
			◯ Breakfast ◯ Lunch ◯ Dinner ◯ Bedtime ◯ Other time _____		
			◯ Breakfast ◯ Lunch ◯ Dinner ◯ Bedtime ◯ Other time _____		
			◯ Breakfast ◯ Lunch ◯ Dinner ◯ Bedtime ◯ Other time _____		
			◯ Breakfast ◯ Lunch ◯ Dinner ◯ Bedtime ◯ 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!