



# Joseph Pfeifer Kiwanis Camp

5512 Ferndale Cutoff \* Little Rock, Arkansas 72223  
Phone (501) 821-3714 \* Fax (501) 821-2629



Email: camp@pfeifercamp.com



# Health

# Form



## Notice and Waiver

By signing this waiver, I understand that Pfeifer Camp is not a medical camp or medical facility, and the camp staff is not trained to treat serious medical conditions, including breathing emergencies. I acknowledge that the camp does not recommend this program for individuals with breathing conditions or history of breathing difficulties, especially those who have had an occurrence within the last year. I understand that breathing difficulties are not covered by the camp's accidental insurance policy, which is available to be purchased by parents. Breathing conditions are considered pre-existing conditions and, therefore, are not included within the coverage provided by the camp's insurance company. I understand and agree that I am responsible for all medical bills that may result from my child being involved in the Pfeifer Camp programs.

I understand that my child must be picked up from the camp immediately at the onset of any serious medical condition, including, without limitation, breathing difficulties coughing, wheezing, tightness in chest, or complaints of difficulty in breathing. I understand that the camp has these policies for the well being and safety of my child.

I understand and assume the responsibility that my child will be participating in the indoor and outdoor recreational activities of the camp and will be exposed to the inherent risks of such activities and the camp's environment.

In consideration for my child participating in the activities of Camp Pfeifer, I hereby release and agree to hold harmless Camp Pfeifer, Kiwanis Activities, Inc., and the Camp Pfeifer staff from any and all claims, causes of action or damages, which I, my child, or our assigns may have now or in the future, known or unknown, as a result of or related to my child's attendance and participation in the activities of Camp Pfeifer.

I have read, understand, and agree to all conditions of this notice and waiver and voluntarily execute it with full knowledge of its significance.

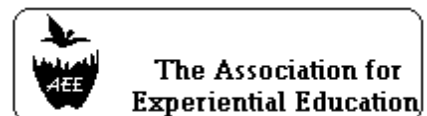
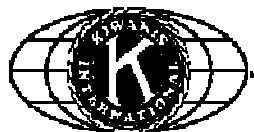
\_\_\_\_\_  
Name of Parent or Guardian (Print)

\_\_\_\_\_  
Name of Child (Print)

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

Project of the Downtown Kiwanis Club



# Health History and Examination Form for Pfeifer Kiwanis Camp

*This page should be completed by parent/guardian of minors or by adult campers or staff*

Return completed form to ... **Pfeifer Kiwanis Camp, 5512 Ferndale Cutoff, Little Rock, AR 72223**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_  
Birthdate \_\_\_\_\_ Sex \_\_\_\_ Age \_\_\_\_ Social Security # \_\_\_\_\_ Religion \_\_\_\_\_  
With whom does this person live \_\_\_\_\_ Relationship to camper \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_  
Business \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell/Pager \_\_\_\_\_  
Second Emergency Contact \_\_\_\_\_ Relationship to camper \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_ Cell/Pager \_\_\_\_\_  
Third Emergency Contact \_\_\_\_\_ Relationship to camper \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_ Cell/Pager \_\_\_\_\_  
Name of dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_  
Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_

**Please include a copy of the applicant's immunization records and birth certificate.**

**Insurance Status** (please check the appropriate box):

Medicaid       AR Kids First       Private       No Insurance

Carrier or Plan name \_\_\_\_\_ Group # \_\_\_\_\_  
Carrier address \_\_\_\_\_ Medicaid # \_\_\_\_\_  
Name of insured \_\_\_\_\_ Relationship to participant \_\_\_\_\_  
Social security number of policy holder or insurance ID number \_\_\_\_\_ Effective Date \_\_\_\_\_

## Important - These boxes must be complete for attendance\*

**Parent/Guardian Authorizations:** This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities, except as noted.

I hereby give permission to the camp to provide routine health care and administer prescribed and/or over-the-counter medications approved by the camp physician and/or parent/guardian. I also give the camp permission to seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

**Signature of parent/guardian or adult camper/staffer** \_\_\_\_\_

Printed Name \_\_\_\_\_ Date \_\_\_\_\_

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

**Signature of minor or adult camper/staffer** \_\_\_\_\_ Date \_\_\_\_\_

\* *If for religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.*

adapted from the American Camping Association, Inc.

Child's Name \_\_\_\_\_

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness, or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have an orthodontic appliance at camp?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness or condition?	<input type="checkbox"/>	<input type="checkbox"/>	14. Have any skin problems (e.g. itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	15. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	16. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	17. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	19. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts, or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	21. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	22. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>	23. Have any dietary restrictions?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had problems with joints (e.g. knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any "yes" answers, noting the number of the questions.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medication allergies (list)**      Describe reaction and management of the reaction.

**Food allergies (list)**      \_\_\_\_\_

**Other allergies (list)** - include insect stings, hay fever, asthma, animal dander, etc.

**Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.**

\_\_\_\_\_

\_\_\_\_\_

**MEDICATIONS BEING TAKEN**

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person takes NO medications on a regular basis.

This person takes medication as follows:

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer: \_\_\_\_\_

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## CAMP PHYSICAL

Return completed form to **Pfeifer Kiwanis Camp**

**About Joseph Pfeifer Kiwanis Camp:** The programs at Pfeifer Camp are very active and strenuous and require that campers be in good physical health. Children with asthma who have had an "attack" within the last year are not recommended for our program related to the following environmental conditions: fireplace smoke in cabins and classroom, excessive dust, rainy days and nights, and spring pollen. The camp is 15 minutes away from the nearest medical facility, and campers may be 15 minutes away from the camp infirmary at any given time. Residential campers must have a completed physical on file. Physicals are considered for one year. If you need more specific information about Pfeifer Camp programs, please call 821-3714.

Name of applicant \_\_\_\_\_

BLOOD PRESSURE \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ PULSE \_\_\_\_\_ RESPIRATION \_\_\_\_\_ TEMP \_\_\_\_\_

The applicant is under the care of a physician for the following condition(s): \_\_\_\_\_

Explanation of any reported loss of consciousness, convulsion, or concussion: \_\_\_\_\_

Does applicant have:	epilepsy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	diabetes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	pediculosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	heart murmurs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	asthma?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	tinea lesions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	scabies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

### **Recommendations and Restrictions while at Camp:**

Any treatment to be continued at camp: \_\_\_\_\_

Any medication to be administered at camp (specific dosages): \_\_\_\_\_

Any medically prescribed meal plan or dietary restrictions: \_\_\_\_\_

Any allergies (food, drugs, plants, insects, etc.) Please describe reaction and management of the reaction: \_\_\_\_\_

**In my opinion, the above named applicant is free from communicable diseases and clear of any condition that would prevent his/her participation in an active camping program.**

**LICENSED PHYSICIAN'S SIGNATURE** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Date of Examination** \_\_\_\_\_ **By** \_\_\_\_\_

**THIS FORM MUST BE SIGNED BY A LICENSED PHYSICIAN OR NURSE PRACTITIONER.**