2019 Doctor's Statement & Sunscreen Authorization
Mt Elim Camp

It is required by the State of Colorado, to be filled out by a licensed physician within one year of camp. Failure to complete this section will prohibit camper from enrollment of the camp program.

Camper's Full Name: _____

Camper's Vital Signs, Weight & Height

Height: _____ **BP: _____**

Weight: _____ **Temp: _____**

Indicate below any history of serious illness, injury, surgery & year of event:

_____

_____

Medications Taken Routinely & as Needed

	Medication or supplement	Dose (# of pills etc)	Schedule (am, pm)	Doctor's initials
1				
2				
3				
4				
5				
6				

Notice: ALL medications, supplements and over the counter medications (this includes Tylenol, cough drops, Benedryl, vitamin C etc.) MUST:

1. **Be in the original container with original labels.**
2. **Have child's name on container. (write with permanent marker)**
3. **Doctor must indicate medications and supplements that child is allowed to use while at camp and the camp nurse will give on schedule**.
   a. Name of med/supplement
   b. Dose
   c. Schedule

Camp nurse would recommend leaving vitamins at home as the child will only miss the 3 full days while at camp. Half day Monday and Friday may be given with parent supervision when home.

I have examined this child and found him/her to be in satisfactory physical condition, free from any contagious disease and capable of active participation in a regular camping program except as follows:

_____

_____

_____ _____

Doctor Signature **Date**

_____ _____

Print Doctor's Name **Doctor's Address/Phone**

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Sunscreen Authorization

Camper's Name _____

As the parent or guardian of the above child, I give permission for the staff at Mt Elim Bible Camp to apply a sunscreen product on my child, as specified below, when he or she will be engaging in outdoor activities. I understand that sunscreen may be applied to exposed skin, including but not limited to the face, tops of ears, nose, bare shoulders, arms and legs. Additionally, I have checked and/or indicated below my directives regarding the type and application of sunscreen:

____ Staff may use the sunscreen that I am providing with this form:
Brand _____ SPF _____

____ In the event that my provided sunscreen is not available, I give permission to use any available sunscreen.

Please do not apply sunscreen to the following areas of my child's body:

_____.

Application Instructions:

_____ As Needed
_____ Specific Times _____

_____
Signature of Parent/Guardian

_____
Date

COLORADO CERTIFICATE OF IMMUNIZATION

www.coloradoimmunizations.com

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 ACIP schedule. Note: Final doses of DTaP, IPV, MMR and Varicella are required prior to kindergarten entry. Tdap is required at 6th grade entry.

Student Name: _____ **Date of birth:** _____

Parent/guardian: _____

Required vaccines

	Immunization date(s) MM/DD/YY						**Titer date*** MM/DD/YY
Hep B 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	

*A positive laboratory titer report must be provided to the school to document immunity.

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

Recommended vaccines

	Immunization date(s) MM/DD/YY						
HPV Human Papillomavirus							
Rota Rotavirus							
MCV4/MPSV4 Meningococcal							
Men B Meningococcal							
Hep A Hepatitis A							
Flu Influenza							
Other							

Health care provider signature or stamp: _____ Date: _____

Student is current on required immunizations for age (circle one): Yes No

OR

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: _____