

DESTINATION IMAGINATION®S' ACCEPT THE CHALLENGE CAMP
PRESENTED FOR IMAGINATION 4 LIFE™ BY INNOVATION TRAINING & CONSULTING, INC.

Health Form: Required Medical Information

The information on this form is not part of the participant/staff acceptance process, but it is gathered to assist us in identifying appropriate care.

To Parent or Guardian:

Participants must submit this medical form signed by a parent/guardian. It is also recommended to have this form signed by licensed health care provider **or** submit a recent (last 2 years) standard school physical form **or** the included health care recommendation form. Please return the completed form(s) and any information you wish us to have regarding medical background (allergies, disabilities, restricted activities, special medication that must be given). ***Please mail or scan and email the form to Camp Administrator at least 2 weeks prior to the first day of camp.*** Any medical information provided will be kept confidential within the camp staff and based on need-to-know.

PARTICIPANT/PARENT INFORMATION

Camp Date(s): _____

Participant Name _____

Birth date: _____ Age: _____ Gender: Male Female

Custodial Parent/Guardian Completing this Form:

Name _____

Phone: Daytime _____ Cell _____

Address (if different from camper) _____

City _____ State/Province _____ Zip _____

Indicate which health forms are enclosed:

_____ this form only, signed by parent/guardian (required)

Recommended but not required:

_____ Accept the Challenge Health Care Recommendation Form signed by licensed medical provider dated within 24 months of camp start date

_____ Previously completed school physical form dated within 24 months of camp start date. If this alternative form is provided, please also complete the following information:



Recommendations or Restrictions at Camp

Treatment or medications (name, dosage, frequency) to be continued at camp:

Any medically-prescribed meal plan or dietary restrictions:

Description of any limitation or restriction on camp activities:

Additional information for camp staff (e.g., allergies, food needs):

Medical Insurance:

Policy# _____ Phone _____

Company _____

Address _____

City, State, ZIP _____

Parent/Guardian Signature _____ Date _____

PLEASE RETURN THIS HEALTH FORM TO:

Diana Baldi, Camp Administrator

148 W Lincoln Ave

Libertyville, IL 60048

Phone: 847-682-4093

Email: diana@innovationtrainer.com



Health Care Recommendation Form
Recommended to be completed by Licensed Medical Personnel or
provide standard school physical completed in last 2 years.

I examined (participant's name) _____ on _____.
Weight _____ **Height** _____

In my opinion, the above applicant ____ is ____ is not able to participate in an active camp program that includes both indoor and outdoor activities.

The applicant is under the care of a physician for the following relevant conditions:

Recommendations or Restrictions at Camp

Treatment or medications (name, dosage, frequency) to be continued at camp:

Description of any limitation or restriction on camp activities:

Additional information for camp staff (e.g., allergies, food needs):

Signature of Licensed Medical Personnel: _____

Printed: _____ Title: _____

Phone: Office _____ Emergency _____

Address _____

City _____ State/Province _____ Zip _____

