2025 VINS NATURE CAMP

Leaders-In-Training
Health and Emergency Care Form

Instructions:

- Please return completed forms **NO LATER** than two weeks prior to the start of camp.
- Return completed forms to:

Mail: VINS Nature Camp
Vermont Institute of Natural Science
PO Box 1281
Quechee, VT 05059

Email: camps@vinsweb.org
Fax: 802.359.5001

General Information

LIT Name: _____ Gender: ☐ M ☐ F ☐ Non-binary

Entering Grade: _____ Age: _____ Birth Date: _____ Pronouns: _____

Parent/Guardian Name: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ E-mail: _____

Address: _____

Second Parent/Guardian Name: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ E-mail: _____

Address (if different than above): _____

Primary contact during camp hours: _____

Best method of contact: _____

Emergency Contacts

If we **cannot** reach the Parent(s)/Guardian(s) listed above, please provide emergency contacts:

	Name	Phone	Relationship to LIT
1.			
2.			

Pick-Up Authorization

Please list **ALL** adults (INCLUDING YOURSELF) authorized to pick up your LIT (**photo ID will be checked**). For the safety and security of your LIT only those listed on this sheet will be allowed to pick up your child, unless they have permission to sign themselves out below. **No exceptions will be made**.

1._____ 3._____

2._____ 4._____

Please check the box below if you would like your LIT to be able to sign themselves out at the end of the camp day.

☐ Yes, I give my LIT permission to sign themselves out at the end of the camp day.

Medical Information

Medical Concerns: Has your LIT experienced, or is currently experiencing, any of the following conditions. If so, please provide specific information including reaction, management, frequency, and any other necessary information.

☐ ADD/ADHD	☐ Cancer	☐ Frequent Headaches
☐ AIDS/ARC	☐ Cramps/Stomach Aches	☐ Hay Fever/Seasonal Allergies
☐ Asthma/Inhaler	☐ Developmental Delays/Disabilities	☐ Heart Disease
☐ Behavioral Issues	☐ Diabetes	☐ High Blood Pressure
☐ Blackouts/Fainting	☐ Ear Infections	☐ Mental Health Issues
☐ Bleeding Disorder	☐ Epilepsy/Seizures	☐ Other (describe below)

Details:

It is your responsibility to supply any necessary medical equipment which relates to a specific medical condition.

Allergies:

Does your LIT have any allergies? ◯ Yes ◯ No

If yes, what is your LIT allergic to?: _____

Does your LIT require an EpiPen? ◯ Yes ◯ No

Describe the allergic reaction including severity:

If your LIT requires an EpiPen, please provide non-expired EpiPens as well as any other medications to treat their reaction. Be sure to complete the medication section of this form.

Immunizations: Please indicate whether your LIT has had the following vaccinations, and the date administered:

COVID-19	◯ Yes	◯ No	Date:_____
TDaP (Tetanus, Diphtheria, Pertussis)	◯ Yes	◯ No	Date:_____
MMR (Mumps, Measles, Rubella)	◯ Yes	◯ No	Date:_____
IPV (Polio)	◯ Yes	◯ No	Date:_____
Varicella (Chicken Pox)	◯ Yes	◯ No	Date:_____

Because our camp program has a potential for communicable diseases, we recommend that program participants are appropriately immunized for, at minimum, the above diseases. This being said, we recognize that some individuals may not be fully immunized for a variety of reasons. If your LIT has not been fully immunized, please explain:

Medications

Regular Medications: List all prescription medications or over-the—counter drugs your LIT regularly takes and reason for taking them. (Use additional sheets if necessary.)

Medications at Camp: If your LIT will be taking any of these medications while at camp or will be bringing any lifesaving medications such as an EpiPen or rescue inhaler, they must be listed below. (Use additional sheets if necessary.)

Medications must be clearly labeled with LIT name, medication name, dosage, time of day to be given, prescribing doctor name and phone number (if applicable).

Medication: _____

Dose: _____ Frequency: _____

Time Taken: ◯ Lunch ◯ Snack ◯ As Needed ◯ Other time: _____

Provide reason for the medication and any notes on giving this medication to your LIT:

Heath Insurance and Physician Information

Medical Insurance Carrier _____ Phone Number _____

Policy or Subscriber Number _____ Group Name or Number _____

Pediatrician's Name _____ Office Phone _____

Medical Waiver

Authorization for Treatment

This health history is correct and accurately reflects the health status of my child.

In case of medical emergency, I understand that every reasonable attempt will be made to contact me, my named emergency contacts, or my child/ward's physician, in that order. In the event that my named contacts or I cannot be reached, I hereby authorize the staff of the Vermont Institute of Natural Science Nature Camp and medical personnel to take emergency measures as needed to safeguard my child/ward's health and wellbeing. I agree to pay for any charges for emergency medical services rendered that are not covered by my personal health insurance. By signing this statement, I affirm that I am legally authorized to do so.

Medication Policy Acknowledgement and Release

In all cases, the term "administration" is equivalent to camp staff maintaining possession of the medication and/or placing it in a secure location until the time it is needed. Camp staff remind LITs at the documented time and will give them the medication container. The LIT must be able to identify the shape/color of their medication and be able to take it on their own.

I give permission to the staff of the Vermont Institute of Natural Science Nature Camp to administer to my child/ward the medications previously listed. I understand that measurement of medication dosage is not the responsibility of camp staff and my child must come to camp with the medication pre-measured for the correct dosage. I also understand that it is my responsibility to inform VINS Nature Camp of any changes in the dispensing of medication in writing.

I recognize and acknowledge there are certain risks of injury/illness in connection with my child/ward's medication. In consideration of the Vermont Institute of Natural Science's administering medication to my child/ward, I do hereby fully release or discharge the Vermont Institute of Natural Science, and its officers, agents, volunteers and employees from any and all claims from injuries, damages and losses I or my child/ward may have (or accrue to me or my child/ward), and arising out of, connected with, incidental to, or in any way associated with the administering of medication.

Parent/Guardian Signature:_____ Date: _____