CHECKLIST

Part 2 - Printable*

- ☐ Guardian Consent Form
- ☐ Medical Form
  - ☐ Insurance Card
  - ☐ Immunization Record
  - ☐ Medicine List
- ☐ Medical History
- ☐ Drop Off/Pick Up Policy

***Please mail to PO Box 50, Sherrill, IA 52073 or scan completed document to registration@albrechtacres.org**

Camp Albrecht Acres · 2022 Camp Application · Part 2

CONSENT OF PARENT/LEGAL GUARDIAN

_______ **(Initial)** I hereby give my permission for my child/adult/self (NAME______________________) to attend Camp Albrecht Acres of the Midwest, 14837 Sherill Road, Sherrill, IA 52073. I also understand that a camper's medical and/or behavioral instability, as determined by the camp's personnel and administration, may result in the camp's inability to serve the camper and may result in the camper being sent home. I hereby agree not to send the camper to camp if he/she has been exposed to a contagious or communicable disease within two weeks of the date they are to attend camp, and I will give notification to the camp regarding the condition immediately. This completed form may be copied for trips out of camp.

_______ **(Initial)** I hereby give medical personnel at Camp Albrecht Acres of the Midwest permission to dispense medication, both prescription and non-prescription, to my camper. I hereby give my permission to the medical personnel or dental personnel selected by Camp Albrecht Acres of the Midwest to order X-Rays, testing, treatments, hospitalization if necessary, to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation to services. I understand every attempt to contact me or my designee in the event of illness or emergency will be made by Camp personnel. I acknowledge receipt of the Health Insurance Portability and Accountability Act (HIPAA) form from Camp Albrecht Acres of the Midwest.

_______ **(Initial)** I hereby release Camp Albrecht Acres of the Midwest, its Board, employees, staff and volunteers from any liability for personal injury, property damage, or death resulting from my/my campers attendance at Camp Albrecht Acres of the Midwest, in both its natural and manmade facilities and grounds. I further assume full responsibility for any personal injury of any description sustained during said camper's voluntary participation in camp activities. I will not hold Camp Albrecht Acres of the Midwest responsible for any damage to or loss of said camper's personal property. I further understand that Camp Albrecht Acres of the Midwest strives to safeguard the health and safety of all campers and precautions are taken to ensure their health, safety and well-being. I hereby give permission to transport camper to activities held outside of campgrounds.

_______ **(Initial)** I recognize that Camp Albrecht Acres of the Midwest is closely monitoring the pandemic and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19, However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by attending Camp. I hereby acknowledge and assume the risk of becoming infected with COVID-19.

_______ **(Initial)** According to Iowa Administrative Code 441 79.9(4): Recipients must be informed before the service is provided that the recipient will be responsible for the bill if a non-covered service is provided.

_______ **(Initial)** I hereby give consent for Camp Albrecht Acres of the Midwest to use photographs of me/my camper for the promotion of camp.

_______ **(Initial)** I hereby state that the information I have already and continue to provide to Camp Albrecht Acres of the Midwest in the form of any part of the camper application, campership financial aid application, and any additional application materials has been filled out accurately and completely to the best of my ability. I understand that the information I have provided enables Camp staff to place myself/my camper with adequate staff members and as a participant of certain activities; if the information I provided proves inaccurate it is the right of Camp Albrecht Acres staff members to deny myself/my camper the right to participate and/or attend.

All lines must be initialed before admittance to camp

(must be signed before admittance to camp)

SIGNATURE OF LEGAL GUARDIAN______________________________________ DATE:____________

PRINTED NAME OF LEGAL GUARDIAN____

CAMP ALBRECHT ACRES MEDICAL FORM

Send or fax information to: Camp Albrecht Acres
PO Box 50, 14837 Sherrill Road, Sherrill, IA 52073
Fax: (563) 552-2732

Patient Name:____

DOB:________________ **Primary Diagnosis:**____________________________________

Date of last physical exam: ______________________ **(Must be within 1 calendar year of the last day of anticipated attendance of camp.)**

BP:________ **Wt:** ________ **Ht:** ________ **P:** ________ **T:** ________ **R:** ________

Physical Exam is within normal limits? □ Yes □ No
(If no, please explain on a separate sheet.)

Does camper have a Do Not Resuscitate Order? □ Yes □ No
(If yes, please enclose copy order.)

Is camper vaccinated against COVID-19? □ Yes □ No **Date:**_______________________________

Does camper have COVID-19 Booster? □ Yes □ No **Date:**_______________________________

In my opinion, the applicant __________ participate in a camp program

- **□ May**
- **□ May Not**
- **□ May with following restrictions** ____

Physician's signature:____ **Date:** ___________

Printed Name: ____

Phone Number: ______________________________

PLEASE ATTACH CURRENT LIST OF MEDICATIONS.

PLEASE ATTACH RECORD OF IMMUNIZATIONS.

For any questions for camp, please email office@albrechtacres.org or call (563) 552-1771.

MEDICAL HISTORY

Pharmacy:____ Phone:___________________________

Insurance Company:__________________________________ Phone:________________________

Medicare/Medicaid Number:_______________________ Title XIX Number:________________

Allergies to: Drugs:____

Food:____

Enviornmental:____

Does camper have seizures? □ Yes □ No

If yes, type:___________________________ Frequency:_____________________________

Most likely to occur:____________________________ Date of last seizure:____________

Description:____

Camper is susceptible to:

- □ Bruises
- □ Shunt
- □ Strokes
- □ Headaches
- □ Heart Problems
- □ Kidney Disease
- □ Bedwetting
- □ Asthma
- □ Eating Disorder
- □ Diarrhea
- □ Constipation
- □ Ulcers
- □ Hernia
- □ Arthritis
- □ Diabetes
- □ Gall Bladder Problems
- □ Other:_______________ ________________________

CAMP MEDICATION REQUIREMENTS AND PACKING:

- **Camper medications must be prepared in a Bubble packs (preferably prepared by a pharmacist). If this is not obtainable please use other form of medication packs(ie. daily dose holders)**
- **Add one additional day's worth of medication.**
- **Current list of camper's medications with name, dose and administration times is also required.**
- **No individual packing techniques (envelopes, bags, bottles) will be accepted.**
- **Failure to have pre-packaged medications will result in delayed check-in and possible fees.**
- **Medications may be shipped to camp in advance of camp attendance; these campers will have preferred check-in.**

PLEASE ATTACH:

- **COPY OF CURRENT MEDICAID/TITLE XIX/INSURANCE CARD.**
- **COPY OF RECORD OF IMMUNIZATIONS**
- **COPY OF CURRENT MEDICATION LIST (non-prescription too).**
- **COPY OF CURRENT MEDICATION ADMINISTRATION RECORDS FOR CAMPERS RESIDING IN GROUP HOMES OR FACILITIES.**

***The American Camp Association requires each camper must have had a medical exam by a licensed provider in the past 12 months. Please see "Medical Form."**

***Camp Albrecht Acres must keep physical, immunization and medication lists on file for credentialing purposes. However, this paperwork is not credible as part of the camper's application for more than the current camp season. Updates must be made each year the camper attends Camp Albrecht Acres.**

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DROP OFF AND PICK-UP POLICY

CHECK-IN TIMES: WEEK

Individuals or Groups of up to 3 campers: Check-in at 1:00pm Sunday
4 or more campers: Check-in at 2:00pm Sunday
***Arrival before designated time will result in a waiting period**

CHECK-IN TIMES: WEEKEND

Individuals or Groups of up to 3 campers: Check-in at 1:00pm Friday
4 or more campers: Check-in at 2:00pm Friday
***Arrival before designated time will result in a waiting period**

CHECK-OUT TIMES: WEEK

All campers must be picked up no later than 10:30AM Friday.
***Sick participants or participants being discharged (voluntarily or not) must be picked up within one hour of the notification call. Exceptions may be made at the discretion of the Supervisor on duty or camp director.**

CHECK-OUT TIMES: WEEKEND

All campers must be picked up no later than 10:00AM Sunday.
***Sick participants or participants being discharged (voluntarily or not) must be picked up within one hour of the notification call. Exceptions may be made at the discretion of the Supervisor on duty or camp director.**

I understand the participant will only be released to a Parent, Legal Guardian, or Emergency Contact. A photo id may be requested for the camper to be released.

I understand that a $25 charge will be billed for every 30 minutes after 10:30am for a late checkout.

Signature of Parent/Legal Guardian:______________________________________ Date: ______________

Printed Name of Parent/Legal Guardian: ____

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IOWA HIPAA MEDICAL AUTHORIZATION RELEASE FORM

I, as the camper or camper's legal representative, authorize Camp Albrecht Acres of the Midwest to release and deliver confidential medical information according to this Authorization:

CAMPER INFORMATION

Name ______________________________________ Date of birth _______________ SSN ________________
Street address ____ City ________________ State _______
Zip __________ Phone number ___________________ Maiden/previous names _________________________
***I hereby give my permission to release any records necessary to the medical personnel or dental personnel selected by Camp Albrecht Acres of the Midwest.**

PURPOSE OF RELEASE

• Transferring medical care • Insurance coverage • Case coordination/referral • Legal purposes •

This authorization is effective for one year from the date on which it is signed. I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance upon it. I understand I have the right to inspect the information to be disclosed upon the proper notification.

The **Releasee** does not require completion of this form as a condition of evaluation or treatment. However, if the evaluation or treatment is solely for the purpose of creating a medical report for a third party, those services are subject to cancellation if authorization to release the information to that party is not provided.

I understand that the person or entity that receives the information requested may not be covered by the federal privacy regulations or is not an individual or entity who has signed an agreement with a covered person or entity and the medical information may no longer be protected by the regulations.

Electronic transmission of records (Faxing/E- mail) I authorize electronic transmission (fax/secure e-mail) of my medical records. If any portion of the fax/e-mail is received by an inappropriate third party in error, I release the Releasee, its physicians and staff of any and all liability relating to the disclosure of said records. Records may be provided in electronic form on a secure disk. Paper records are available upon request.
I understand that information to be released may include material that is protected by Federal and/or State law concerning mental health, substance abuse treatment, AIDS–related information and genetics unless I specifically deny the release by initialing the category below:

Please initial beside any category you do NOT want to be released. Substance abuse (drug or alcohol) ______
Genetics ______ Mental health information ______ AIDS–related information, diagnosis, & test results ______

I SPECIFICALLY AUTHORIZE disclosure and redisclosure of this confidential information to the person or entity listed above. In order for the information to be released, you must sign below. If mental health information is being disclosed, I acknowledge receipt of a copy of this authorization.

Signature of camper or camper's legal representative___________________________________ Date_________

Printed name and relationship of campers's legal representative_______________________________________
(Authority to act on behalf of patient requires attachment of such documentation)