CHECKLIST

Part 2 - Printable forms*

- ☐ Guardian Consent Form
- ☐ Physician Exam Form
- ☐ Packing List
- ☐ HIPAA Medical Authorization Release Form

***Please mail to PO Box 50, Sherrill, IA 52073, fax (563) 522-2732 or email registration@albrechtacres.org**

Camp Albrecht Acres · 2024 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_____

Physician Examination Form

To be completed by Licensed Medical Personnel
(Physician, Physician Assistant or Nurse Practitioner)

Please list the applicant's primary physician if different from the licensed medical personnel filling out the form. The person named below has been accepted to camp and has permission to engage in all camp activities except as noted below. Camp Albrecht Acres (CAA) has been given permission to provide routine health care under the guidance of the camp's medical director, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests by the Camper/Guardian signing the releases section of the camp application. The person named below has also agreed to release any records necessary for treatment, referral, billing, or insurance purposes.

By the camper/guardian signing the releases section on the camp application, CAA has been given permission to arrange necessary related transportation for the person named below. If the guardian/parent cannot be reached in an emergency, they hereby gave permission to the physician selected by the camp to secure and administer treatment, including hospitalization, by signing the releases section of the camp application.

Camper Name: _____Date of Birth _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____)_____

Parent/Guardian Name: _____ Relationship: _____Phone: (___)_____

Primary Physician: _____Phone #: (_____)_____

Medical Assistance/I.D. # _____ Insurance #: _____ Group #: _____

Insurance Company: _____ Insurer's Name: _____

I examined this individual on ___/____/_____. Camp Albrecht Acres requires **annual exams**.
ALL exams must be completed on this form and returned to camp *three weeks before camp attendance.*
Medical Exams completed on any other documentation will NOT be accepted. Campers who arrive to camp for their session who do not have a completed Physical WILL NOT be permitted to stay until one is received.

BP:_____ Pulse: _____Weight: _____Height:_____

Free of Communicable Disease as of _____

Description of any camp activity restrictions:

Strenuous Exercise/Physical Activity:

Hiking:

Swimming:

Other Restrictions:

Blood/Body Fluid Precaution: (circle one) Yes / No | If yes, Type: _____

Non-Drug Allergies (please explain reaction):_____

_____

Drug Allergies (please explain reaction):_____

_____

Does this person have a history or experienced seizures or convulsions? _____ Date of last seizure:_____

Type of seizures: _____ Frequency: _____

At what point do we call EMS? _____

Additional information regarding seizures: _____

_____

THIS FORM IS TO BE RETURNED NO LATER THAN THREE WEEKS PRIOR TO ATTENDANCE.

Has this person been immunized against the following? If so, the most recent date,
MMR #1_____ MMR #2_____ Tetanus_____ Pertussis_____ TB Skin Test_____

Hep B Vaccine #1: _____ Hep B Vaccine #2: _____ Hep B Vaccine #3: _____

If not immunized for tetanus in the past 10 years, please do so prior to attendance.

Is the following normal? If abnormal, please Explain.

	Normal	Abnormal	Explanation
Ears			
Nose			
Throat			
Skin			
Eyes			
Scalp			
Heart			
Lungs			
Extremities			
Abdomen			
Varicosities			
Genitalia			
Neurologic			

Is there a history of the following? If yes, explain.

	History	No History	Explanation
Asthma			
Hernia			
Kidney Disease			
Diabetes			
TB			
Hepatitis			
Heart Disease			
Freq. Colds			
Stomach Disorders			
Previous Surgery			
Recent Illness			
Other			

Further recommendations for camp medical staff (current health conditions requiring additional attention, treatment, or special considerations while at camp):_____

_____

I have examined the herein named individual and have reviewed the health history and find this person to be free of any contagious disease. I find this individual able to participate in a camp experience with the previously listed limitations.

_____
Signature of Licensed Medical Personnel Date

_____
Printed Name Title

_____
Address

_____
Phone Fax

THIS FORM IS TO BE RETURNED NO LATER THAN THREE WEEKS PRIOR TO ATTENDANCE.
ANY CAMPER THAT ARRIVES AT CAMP WITHOUT THIS FORM SIGNED WILL BE SENT HOME.

Packing List

Camper Name: _____

The following is a *recommended* list of items to bring to camp; please adjust according to the needs of your camper.

Parents/caregivers: Please complete the first column and bring to camp.

- **Please note:**
- Our laundry facilities are limited, please bring enough clothes for the entire week. All items brought to camp must be plainly, durably and obviously labeled with the camper's full name.
- We cannot assume responsibility for lost and/or damaged items.

ITEM	Description / Number Sent to Camp	Arrival At Camp (Counselors)	Number Sent Home (Counselors)	Missing
Spending Money ($15-$40)				
Clothing:				
2-3 sleeping outfits				
1 pair shower shoes/flip flops				
2 pairs comfortable shoes				
6 pair socks				
1 swim suit (1 piece only)				
8 pc Underwear				
3 sweaters/sweatshirts				
1 jacket				
Cap or hat for sun protection				
8 shirts				
4 shorts				
1 jeans/slacks				
Personal Items:				
Soap with case				
Shampoo				
Sunscreen Minimum 30 SPF				
Shaving items				
Feminine hygiene products				
Deodorant				
Comb/brush				
Toothbrush & toothpaste				
Bug Spray				
Other:				
Dirty clothes bag				
Pillow, if needed				
Some campers may also need to bring:				
Clothing Protectors (Bibs)				
Incontinent Briefs/Wipes				
Hearing Aids				
Glasses				
Dentures				
Other:				
Other:				

Camp Albrecht Acres prohibits the following items on camp property: pets, firearms, alcoholic beverages, or illegal drugs.

Camp Use Only: Counselor's Name:_____ Date:_____

Camper is wearing:_____

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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)