Health Care Action Plan- BASIC

Please return form to **B.A.S.E. Camp**
1224 East Elizabeth St, Fort Collins, CO 80524
Fax: 970/ 377-9865

Child's
Photo Here

Name _____ D.O.B. _____ Age _____ School _____Grade _____

Parent/Guardian _____

Address _____ City/State/ Zip _____

Work Phone (mother) _____ (father) _____ Home Phone _____

Cell Phone (mother) _____ (father) _____

Emergency Contact _____ Relationship _____ Phone _____

Primary Care Provider _____ Phone _____

Specialist _____ Phone _____

Description of illness or condition:

_____

_____

Medication: _____ Dose: _____ Time: _____

Physical Restrictions:

_____

_____

Concerns/Urgent Action(s):

_____

_____

Comments:

_____

_____

I give permission for the information contained on this HCAP to be shared with adults in B.A.S.E. Camp that will be working with my child on a need-to-know basis. This HCAP will remain in effect for one year or until the health status or physician's orders change. It is the responsibility of the parent/guardian to notify the B.A.S.E. Camp staff whenever there is any change in the student's health status or care.

Parent/Guardian (print) _____ (sign) _____ Date _____

Doctor (print) _____ (sign) _____ Date _____