WESTERN DISTRICT
CAMPING MINISTRIES COMMITTEE

Health Information & Activities Permission Form

Camper/Staff Name: _____ **Camp Session:** _____

Personal Information:

Camper/Staff Address: _____

_____

Date of Birth: _____

Parent/Guardian Name: (Emergency Contact #1 for Staff) _____ Cell: _____

Work: _____

Other Emergency Contact: _____ Cell: _____

Camper's Personal Insurance Information:

Carrier/Plan Name:_____ Group #:_____

Insured Name: _____ SS# or Insurance ID#: _____

Carrier Address: _____

_____

Authorizations/Permissions (Please check):

☐ I hereby give permission to the health professional selected by the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for camper. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the camper/staff named above. I understand the information on this form will be shared on a "need to know" basis with camp staff.

☐ The camper/staff has permission to leave camp property with authorized camp personnel to participate in off-site activities such as canoeing, caving, hiking, overnight camping. In addition, this form may be copied for such trips.

☐ This camper/staff can participate in all programs and activities of the camp without restrictions

Allergy Information:

Does camper/staff have allergies? Yes No If Yes, please list all allergies (food, medicine, asthma, bee stings, etc.)

_____

_____

☐ **Camper/staff has never been stung by a bee, so we are unsure if he/she is allergic.**

Please describe any restrictions (dietary, no running, no swimming, etc. or other information you feel to be important.) _____

_____

Medication: ☐ This camper/staff will not take any daily medication while attending camp.

If your camper/staff will be taking any type of medication, including vitamins & natural remedies:
- -be sure camper name, medication name & how medication is to be given is clearly marked on container(s).
- -bring prescription medicines in the original pharmacy containers with directions & dosage label.
- -please bring only the amount of each medication the camper will need at camp.
- -fill out medication form below.

				When given?				
Name of Medication	Reason for taking	Dosage	How given?	Breakfast	Lunch	Dinner	Bedtime	Other

Are there any medications that the camper/staff member should NOT be given? This includes any pain relievers, cough medicines, aloe, antihistamines, antibiotic cream, band-aids, etc… **Please list all that apply.**

☐ **I certify that my child/I is/am up-to-date on all required immunizations. I relieve the camping facility of any responsibility for issues which may arise should this information be false.** *Please attach a copy of your child's or the staff member's immunization records. Make sure that this includes your child's or your(staff) last tetanus shot.*

General Health History: Please circle the answer to these questions and explain any "yes" answers in the space below.

Has/does the camper/staff:

ever been hospitalized?..... yes no
ever had surgery?..... yes no
have recurrent/chonic illnesses?..... yes no
had a recent infectious disease?..... yes no
had a recent injury?..... yes no
have asthma/wheezing/shortness of breath?..... yes no
have diabetes?..... yes no
have headaches?..... yes no
have skin problems?..... yes no
have fainting or dizziness?..... yes no
passed out/had chest pain during exercise?..... yes no
had mononucleosis during the past 12 months?.. yes no
if female, have problems with menstruation?..... yes no
have problems with falling asleep/sleepwalking? yes no
have back/joint problems?..... yes no
have bedwetting problems?..... yes no
have problems with diarrhea/constipation?..... yes no

ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)?..... yes no
ever been treated for emotional or behavioral difficulties or an eating disorder?..... yes no
seen a professional to address mental/emotional health concerns in the past 12 months?..... yes no
had a significant life event that continues to affect the camper's life? (abuse, death of a loved one, family changes)…….. yes no

Please explain any "yes" answers here or on another sheet of paper if necessary.

"I verify that this health history is correct and accurately reflects the health status of the camper/staff to whom it pertains."

_____ _____

Signature of Custodial Parent/Guardian of camper/Staff member Date