Health History Form
Children/Youth Campers

Camp & Retreat Ministries
Desert Southwest Conference

Revised 10/2015

Camper Name:_____
First Middle Last

☐ Male ☐ Female Child's Weight: _____

Birth Date: _____ (mm/dd/yyyy) **Age while at Camp** _____

Camper's Home Address: _____
Street Address City State Zip Code

Parent/Guardian Name(s): _____

Phone: (_____) _____ Work/Other Phones: (_____) _____

Home Address:_____
(if different from above) Street Address City State Zip Code

If parent not available in emergency, notify: _____

Address: _____ **Phone:** (_____) _____
Street Address City State Zip Code

Name of camper's primary doctor(s): _____ **Phone**: (_____) _____

Allergies: Does camper have any known allergies? ☐Yes ☐No (If "yes", please specify substance & reaction)

Allergies to medications: _____

Food allergies: _____
(Please list any dietary restrictions on page 2 of this form)

Other allergies (e.g. environmental) _____

Does your child require an Epi Pen?
☐Yes ☐No
If your child requires an Epi Pen, provide two non-expired Pens.

Note: This camp cannot provide a peanut-free environment.

Medical Insurance Information: This camper is covered by family medical/hospital insurance ☐Yes ☐No

Insured's Name: _____

Insurance Company: _____Policy Number_____

Group Subscriber's Name: _____Insurance Company Phone Number: (_____)_____

Immunization Records:
Is this camper up-to-date on all immunizations [including Tetanus, Measles/Mumps/Rubella (MMR) and Polio (IPV)]? ☐Yes ☐No

Date of Last Tetanus shot: _____ Blood Type (if known) _____

If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent/Guardian: _____Date: _____Relationship to Camper: _____

Parent/Guardian Authorization & Consent for Medical Treatment

This child has permission to take part in all camp activities under supervision unless limitations are noted on this form, and I agree that the camp or camp personnel will not be held responsible for accidents arising therefrom. I hereby give permission to 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 my child.

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 person names above. This completed health form may be photocopied for trips out of camp.

Signature of Parent/Guardian: _____ Date Signed _____

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Children/Youth Campers Page 2

Camper Name:_____

Birth Date: _____(Month/Day/Year)

Medication: Please check the appropriate box: This camper ☐ **will** / ☐ **will not** take any daily medications while attending camp.
("Medication "is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies.)
Medications sent with the camper **MUST BE IN ORIGINAL CONTAINERS** (no exceptions) and must be labeled with the camper's name and the name and dose of the medication. Provide enough of each medication to last the entire time the camper will be at camp.

Name of Medication	Reason for taking it

The following non-prescription medication may be stocked in the camp health center and are used on an as-needed basis to manage illness and injury. **Please check "Yes" or "No" to give consent for your child to receive if necessary.**

Acetaminophen (Tylenol)	☐Yes	☐No	Pseudoephedrine decongestant (Sudafed)	☐Yes	☐No
ASA (Aspirin)	☐Yes	☐No	Guaifenesin cough syrup (Robitussin)	☐Yes	☐No
Phenylephrine decongestant (Sudafed PE)	☐Yes	☐No	Dextromethorphan cough syrup (Robitussin DM)	☐Yes	☐No
Generic Antihistamine/allergy medicine	☐Yes	☐No	Generic cough drops	☐Yes	☐No
Calamine Lotion	☐Yes	☐No	Antibiotic cream	☐Yes	☐No
Laxatives for constipation (Bisacodyz, Milk of Magnesia)	☐Yes	☐No	Antacid (Tums, Maalox)	☐Yes	☐No
Imodium/loperimide for diarrhea	☐Yes	☐No	Sunburn Spray (Solarcaine)	☐Yes	☐No
Ibuprofen (Advil, Motrin)	☐Yes	☐No	Sunscreen	☐Yes	☐No

General Health History: Has/does the camper (Check "Yes" or "No" for each statement):

1. Ever been hospitalized?	☐Yes	☐No	10. Wear glasses, contacts or protective eyewear?	☐Yes	☐No
2. Ever had surgery?	☐Yes	☐No	11. Had fainting or dizziness?	☐Yes	☐No
3. Have recurrent/chronic illnesses?	☐Yes	☐No	12. Passed out/had chest pain during exercise?	☐Yes	☐No
4. Had a recent infectious disease?	☐Yes	☐No	13. If female, have problems with periods/menstruation?	☐Yes	☐No
5. Had a recent injury?	☐Yes	☐No	14. Have problems with falling asleep/sleepwalking?	☐Yes	☐No
6. Had asthma/wheezing/shortness of breath?	☐Yes	☐No	15. Have a history of bedwetting?	☐Yes	☐No
7. Have diabetes?	☐Yes	☐No	16. Have problems with diarrhea/constipation?	☐Yes	☐No
8. Had seizures?	☐Yes	☐No	17. Have any skin problems?	☐Yes	☐No
9. Had headaches?	☐Yes	☐No	**Please explain "Yes" answers in the space below:**		

Mental, Emotional, and Social Health: Has the camper (Check "Yes" or "No" for each statement):

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)?	☐Yes	☐No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?	☐Yes	☐No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?	☐Yes	☐No
4. Had a significant life event that continues to affect the camper's life?	☐Yes	☐No

Please explain "Yes" answers in the space below:

Diet, Nutrition: ☐This camper eats a regular diet. ☐This camper eats a regular vegetarian diet. ☐This camper has special dietary needs.
(Please describe below):

Note: Campers needing dietary assistance must contact the camp 10 days prior to the event to discuss their needs with food service staff.

Activity Restrictions: Campers will participate in a variety of activities, including arts/crafts, hiking, team sports, & field games. If more information is needed, please contact the Camp Dean directly. Based on this information, please select the appropriate response:

☐ I feel the camper can participate without restrictions.

☐ I feel the camper can participate with the following restrictions or adaptations. **(Please describe below.)**

Note: Campers must have shoes with closed toes and heels for general wear.

Additional Information: Please provide in the space below any additional information about the camper's health you think is important or may affect the camper's ability to fully participate in the camp program.