2021 CAMPER HEALTH FORM

FOR OFFICIAL USE: Camper Name _____ Session _____ Year _____

Camper Name (Print)_____
Birth Date:_____Gender:_____ Age:_____Grade in fall:_____

Parent/Guardian:_____Home Phone:(___)_____
Address:_____Work Phone: (___)_____
City:_____State:_____Zip:_____Cellular Phone:(___)_____

In an emergency situation, use these contacts as necessary:
Second Parent/Guardian:_____Home Phone:(___)_____
Work Phone:(___)_____Cellular Phone:(___)_____
Emergency Contact:_____
Home Phone:(___)_____Work Phone:(___)_____

Staff's Physician:_____Phone:(___)_____

Family Insurance Company:_____Policy #_____
Insurance Subscriber's Name:_____SS#_____
Insurance Claims Address:_____
Pre-Authorization Phone # if required (___)_____

Authorization – Must be signed.

In signing this authorization, I acknowledge that I have read the event description and am aware that the activities associated with this event entail certain inherent risks including damage to property, personal injury, and even death. In consideration for being permitted to participate in this event, I agree to assume all such risks and hereby release and discharge Holston Conference Camp and Retreat Ministries, Inc., it's affiliated camps, officers, sponsors, trustees, employees, agents and other aids and/or volunteers from any and all liability for any and all damage, loss, injury, or death of every kind and nature whatsoever which in any way arises out of my participation in this event.

I hereby give permission to the camp to provide routine health care, administer prescription drugs, and seek emergency medical treatment including ordering X-rays and/or routine tests. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment, and to order injection and/or anesthesia and/or surgery for me/or my child as named above.

The health history on pages 2 and 3 is correct so far as I know.

The person herein described has permission to engage in all prescribed camp activities except as noted.

I give permission for me/my child to be transported in a private vehicle if necessary.

I give permission for photographs taken of me/or my child to be used for camp publicity, printed or electronic.

Signature of parent/guardian_____

This form may be photocopied for use out of camp. **Date**_____

Camper Name (Print)_____

CAMPER HEALTH HISTORY AND PROFILE

General Health Status

	Yes	No
Had any recent injury, illness or infectious disease?	☐	☐
Have a chronic or recurring illness/condition?	☐	☐
Ever been hospitalized?	☐	☐
Ever had surgery?	☐	☐
Have had a head injury?	☐	☐
Have frequent headaches?	☐	☐
Ever been knocked unconscious?	☐	☐
Ever had frequent ear infections?	☐	☐
Ever fainted?	☐	☐
Ever had seizures?	☐	☐
Ever had chest pains during or after exercise?	☐	☐
Ever had high blood pressure?	☐	☐
Ever been diagnosed with a heart murmur?	☐	☐
Ever had back problems?	☐	☐

	Yes	No
Ever had problems with ankle or knee joints?	☐	☐
Have any skin problems (itching, rash, etc)?	☐	☐
Have diabetes?	☐	☐
Have asthma? Does camper carry an inhaler?	☐	☐
Had mononucleosis in last 12 months?	☐	☐
Had problems with diarrhea/constipation?	☐	☐
Have problems with sleepwalking?	☐	☐
Have history of bed-wetting?	☐	☐
Ever had an eating disorder?	☐	☐
Wear Glasses, contacts or protective eye wear?	☐	☐
Have an orthodontic appliance at camp?	☐	☐
Ever had emotional difficulties requiring prof. help?	☐	☐
Ever been diagnosed with ADD/ADHD	☐	☐
If female, has started menstruating?	☐	☐

Please explain "yes" answers:_____

_____

List other Physical, Emotional, Behavioral, or Mental Health Concerns _____

_____

Has camper ever had an allergic reaction to: (describe what sets off reaction and its severity)

Foods: (Please list)_____

Drugs: (Please list)_____

Insect Stings:_____Has camper ever been stung by a bee?_____ Does camper carry an Epi-pen?_____

Ivy Poisoning:_____Other:_____

Immunization Record (complete or attach a copy of Vaccine Administration Records)

Which of the following has the participant had?

- ☐ Measles DTP
- ☐ Chicken pox
- ☐ German Measles
- ☐ Mumps
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C

TB Mantoux Test
Date of last test _____
Result: Positive ☐ Negative ☐

Please give all dates of immunization for:

Vaccine: Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
TD (tetanus/diphtheria)						
Tetanus						
Polio						
MMR						
or Measles						
or Mumps						
or Rubella						
Haemophilus influenza B						
Hepatitis B						
Varicella (chicken pox)						

Parent/Guardian Signature _____ **Date**_____

Camper Name (Print)_____

MEDICATIONS

All medications brought to camp, both prescription and non-prescription, must be in the original containers and clearly labeled with campers name. All prescription medications will be dispensed according to physician's instructions.

Prescription and Routine Medications – Please list all medications to be taken regularly throughout the camp weekend listing exact dosage and dispensing orders prescribed by your doctor. Medications must be in original containers.

Medication	Dosage	Times Taken (Breakfast, Lunch, Supper, Bed, Other)

Parent/Guardian Signature verifying instructions:_____ Date _____

If dispensing orders differ from original container's label,
a Physician's signature is required: _____ Date _____

Over-The-Counter Medications - By **checking** the appropriate box, I give permission for me/my child to receive the following over-the-counter medications according to the specific directions on the product label unless otherwise directed by a physician.

Symptom	Medication
Headache, Fever	☐ Acetaminophen (Tylenol)
Cramps, Muscle Pain, Inflamation	☐ Ibuprofen
Upset stomach	☐ Maalox ☐ Mylanta ☐ Tums ☐ Pepto-Bismol
Diarrhea	☐ Kaopectate ☐ Imodium Liquid
Constipation	☐ Milk of Magnesia
Localized Allergic Reactions	☐ Benadryl
Sore Throat	☐ Sore Throat Lozenge
Itching (Rash)	☐ Hydrocortisone Cream ☐ Calamine Lotion
Insect Sting	☐ Insect Bite Relief (Sting Kill) ointment
Mosquito Protection	☐ Lotion containing DEET
Sun Burn Protection	☐ Sunscreen Lotion

No oral medications will be given without specific parental authorization.

List any over-the-counter oral or topical medications which you/your child should **not** receive.

_____

Parent/Guardian Signature _____ **Date**_____