

**Bring Form
to Camp!**

Health History for Camp
The Division for Outdoor Ministries
Ohio Conference, United Church of Christ
Templed Hills and Pilgrim Hills Camps

Year _____

>>>> Photocopy of front and back of health insurance card must be attached to this form. _____

Name _____ Birth date _____ Age at camp _____
Last First Middle

Home address _____
Street address City State Zip

Social security number of participant _____ Gender: Male _____ Female _____

Custodial parent/guardian _____ Phone _____

Home address _____
(If different than above) Street address City State Zip

Cellular Phone _____ Business Phone _____

Second parent or guardian or emergency contact _____

Home address _____
(If different than above) Street address City State Zip

Cellular Phone _____ Business Phone _____

In an emergency, *if parents/guardians are not available*, notify:

Name _____

Relationship _____ Phone _____

Address _____
Street address City State Zip

Insurance Information:

Is the participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name _____ Group # _____

>>>> Photocopy of front and back of health insurance card must be attached to this form. _____

Name of family physician _____ Phone _____

Name of family dentist/orthodontist _____ Phone _____

Name of medical specialist _____ Phone _____

***** Important - This box MUST BE signed for attendance**

____ This health history is correct so far as I know, and the person described here has permission to engage in all camp activities except as noted.

Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, and necessary transportation for me or my child. In the event I cannot be reached (or cannot speak) in an emergency, I give permission to the physician selected by the camp manager to secure and administer treatment, including hospitalization, for my child (or myself) as named above. * (NOTE: Parents will be contacted if the camper has an illness or accident that is of concern to the Health Caregiver and Camp Manager. Parents will be contacted/consulted in the event that a trip to Urgent Care, Emergency Room or other off-site medical attention is necessary. In the event that the parents cannot be reached, the Health Caregiver or Camp Manager will try to reach an Emergency Contact Person listed above.) I also give permission to the medical personnel to administer over-the-counter medication (as listed on page 3) as deemed appropriate according to the camper's complaints or condition. The dosage or applications will be directed on the labels of each medication and may be the generic equivalent. The completed forms may be photocopied for trips out of camp.

Signature of parent/guardian or adult camper/staff _____

Printed Name _____ Date _____

Cabin or Group _____

Name _____

***** If for religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.**

Health History

The following must be filled in by the parent/guardian, or adult camper or staff member. The intent of this information is to provide camp healthcare personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide completed information so that the camp can be aware of your needs.

Allergies: List all known. Possible reaction and management of the reaction.

Medication Allergies (List)

Food Allergies (List)

Other Allergies (List) - Include insect stings, hay fever, asthma, animal dander, etc.

Restrictions

The following restrictions apply to this individual:

Dietary

- Does not eat red meat Does not eat pork Does not eat eggs
 Does not eat poultry Does not eat seafood Does not eat dairy products
 Other (Describe)

Explain any restrictions to activity (e.g., what cannot be done, what adaptations or limitations are necessary)

Medications Being Taken:

Please list ALL medications (including over-the counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person takes NO medications on a routine basis.

This person takes medications as follows:

Med #1 _____	Dosage _____	Specific times taken each day _____
Reason for taking _____		
Med #2 _____	Dosage _____	Specific times taken each day _____
Reason for taking _____		
Med #3 _____	Dosage _____	Specific times taken each day _____
Reason for taking _____		

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer:

Circle:

Which of the following has the participant had?

- Chicken Pox
- Measles
- German Measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

- TB Mantoux Test
- Date of Last Test _____
- Result: Positive Negative

Please give all dates of immunizations for:

Vaccine	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____	_____
MMR		_____	_____	_____	_____	_____	_____
or Measles		_____	_____	_____	_____	_____	_____
or Mumps		_____	_____	_____	_____	_____	_____
or Rubella		_____	_____	_____	_____	_____	_____
Haemophilus Influenza B		_____	_____	_____	_____	_____	_____
Hepatitis B		_____	_____	_____	_____	_____	_____
Varicella (Chicken Pox)		_____	_____	_____	_____	_____	_____

General Questions (Explain "yes" answers below.)

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness, or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>
2. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (e.g., itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
5. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
7. Wear glasses, contacts, or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
8. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29. Ever had problems with homesickness?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	30. Can the camper swim?	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>			
15. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>			
16. Ever had problems with joints (e.g., knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>			
17. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any "yes" answers, noting the number of the questions.

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

Over the Counter Medications (if you do not want your child treated with any of the following while at camp, cross it off and initial)

Camper Complaint

- Minor aches & pains, headaches, toothaches, or elevated temperature
- Itching, rash, poison ivy, insect bites or sunburn
- Mild diarrhea (w/o other symptoms)
- Upset stomach
- Minor cuts, scratches, abrasions
- Mosquito, insect bites
- Itchy, watery eyes, sneezing, runny
- Stuffy Nose
- Sore throat
- Sun exposure

Medicine Administered (May be generic equivalent)

- Motrin or Tylenol
- Benadryl, Calamine, Aveno, 1% Hydrocortisone Cream, Technu, Aloe
- Immodium
- Tums, Pepto Bismal, Mylanta
- Triple antibiotic (Neosporin), Sterile Wipes
- Insect repellent, Skeeter Stik, After Bite
- Benadryl tablet
- Sudafed
- Throat lozenges
- Sunscreen

Camp staff use only

Are there any changes on this sheet since it was filled out? Yes No (Camp Staff circle)

The Ohio Conference Outdoor Ministries highly recommends that a camper receive a medical evaluation before attending camp.

Health Care Recommendations by Licensed Medical Personnel

I examined this individual on _____ . A new exam is not necessarily required for camp attendance.

BP _____ Weight _____ Height _____

In my opinion, the above applicant _____ is _____ is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

Recommendations and Restrictions at Camp

Treatment/Medications to be continued at Camp (name, dosage, frequency):

Any medically-prescribed meal plan or dietary restrictions:

Description of any limitation or restriction on camp activities:

Additional information for health care staff at the camp:

Signature of Licensed Medical Personnel: _____	
Printed _____	Title _____
Address _____	
Phone _____	Date _____

For camp use only:

Screening Record: Date screened _____	Time _____ am pm
Meds received? _____ Yes (if yes, see page 2)	_____ No
Current health needs identified _____	

Notes _____	
Screened by _____	