WESTERN DISTRICT CAMPING MINISTRIES COMMITTEE

Health Information & Activities Permission Form

Camper Name: ______________________________ **Camp Session:** ____________________________

Personal Information:

Camper Address ______________________________ Camper Date of Birth ________________________

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Parent/Guardian Name : ________________________ Phone: Day __________________ Cell ______________

Other Emergency Contact: ______________________ Phone: ________________________________

Camper's Personal Insurance Information:

Carrier/Plan Name______________________________ Group # __________________________

Insured Name: ______________________________ SS# or Ins ID # ______________________

Carrier Address ______________________________

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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 named above. I understand the information on this form will be shared on a "need to know" basis with camp staff.

☐ The camper 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 can participate in all programs and activities of the camp without restrictions

Allergy Information:

Does camper have allergies? ___yes ___no?
If yes, please list all allergies (food, medicine, asthma, bees stings, etc...). ________________________________

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___ **Camper 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 will not take any daily medication while attending camp.

If your camper 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.

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

Are there any medications that the camper 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 is 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 immunization records. Make sure that this includes your child's 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:

ever been hospitalized?................................. yes no
ever had surgery?.. yes no
have recurrent/chronic 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 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
have skin problems?... yes no

ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?............ 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 on the back of this sheet.

"This health history is correct and accurately reflects the health status of the camper to whom it pertains."

______________________________ ______________

Signature of Custodial Parent or Guardian Date