WESTERN DISTRICT
CAMPING MINISTRIES COMMITTEE

Health Information & Activities Permission Form

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

Personal Information:

Camper/Staff Address _____ Camper/Staff Date of Birth _____

_____

Parent/Guardian Name : _____ Phone: Day _____Cell _____
(Or Emergency Contact #1 for Staff)
Other Emergency Contact:_____ Phone: _____

Camper's Personal Insurance Information:

Carrier/Plan Name_____ Group # _____
Insured Name: _____ SS# or Ins 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, bees 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.

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/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	have fainting or dizziness?.....	yes	no
ever had surgery?.....	yes	no	passed out/had chest pain during exercise?.....	yes	no
have recurrent/chronic illnesses?.....	yes	no	had mononucleosis during the past 12 months?.	yes	no
had a recent infectious disease?.....	yes	no	if female, have problems with menstruation?.....	yes	no
had a recent injury?.....	yes	no	have problems with falling asleep/sleepwalking?	yes	no
have asthma/wheezing/shortness of breath?..	yes	no	have back/joint problems?.....	yes	no
have diabetes?.....	yes	no	have bedwetting problems?.....	yes	no
have headaches?.....	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/staff to whom it pertains."

_____ _____

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