

Health Form



CAMPS & RETREATS
United Methodist Church

Name _____
Last First Middle
Grade Entering in Fall _____ Age at camp _____ Birth date _____

Home Address _____
Street City State Zip

Gender: Male Female

Custodial parent/guardian _____ Phone _____

Home Address _____
(If different from above) Street City State Zip

Cellular Phone _____ Business Phone _____

Second parent or guardian or emergency contact _____

Address _____ Phone _____
Street City State Zip

Cellular Phone _____ Business Phone _____

If not available in an emergency, notify:

Name _____ Relationship _____

Address _____ Phone _____
Street 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 COMPLETE FOR ATTENDANCE

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed 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 in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child as named above. *(Note: Parents will be contacted if the camper has an illness or accident that is of concern to the Health Officer and Director. 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 Officer or Director will try to reach an Emergency Contact Person listed above). I also give permission to the medical personnel to administer over the counter medications (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 participant/staff _____ Date _____

Health History

The following information must be filled in by the parent/guardian, or adult participant or staff member. The intent of this information is to provide appropriate care. Please keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon arrival at camp. Provide complete information so that the camp can be aware of your needs. **All questions and blanks MUST be filled in or answered with at least "Yes", "No" or "N/A".**

Allergies (List all known)

Describe reaction and management of the reaction.

Medication Allergies (list)

Food Allergies (list)

Other Allergies (list, including insect stings, hay fever, asthma, ivy poisoning, animal dander, etc.)

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. All medications, including over-the-counter/nonprescription, must be turned in to the Health Officer at registration.**

- 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 if needed.

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

RESTRICTIONS

Please list any dietary restrictions that apply to this individual (e.g. vegetarian, lactose intolerance, etc.)

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

Explain any activities that need to be encouraged

Which of the following has the camper had?

- Measles
- Chicken pox
- German measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Rheumatic Fever
- 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
DTP		_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____	_____
MMR		_____	_____	_____	_____	_____	_____
or Measles		_____	_____	_____	_____	_____	_____
or Mumps		_____	_____	_____	_____	_____	_____
or Rubella		_____	_____	_____	_____	_____	_____
Haemophilus influenza B		_____	_____	_____	_____	_____	_____
Hepatitis B		_____	_____	_____	_____	_____	_____
Varicella (chicken pox)		_____	_____	_____	_____	_____	_____
Other (specify) _____		_____	_____	_____	_____	_____	_____

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 an orthodontic appliance being brought to the mission trip?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?.....	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (e.g. itching, rash, acne)?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?.....	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?.....	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis (mono) in the past 12 mos?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?.....	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?... ..	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?.....	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking?.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eyewear?.....	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, has she menstruated?.....	<input type="checkbox"/>	<input type="checkbox"/>
9. Had frequent ear infections?.....	<input type="checkbox"/>	<input type="checkbox"/>	a) If no, has she been told about it with instructions?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>	b) If yes, does she have an abnormal menstrual history?.....	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bedwetting?.....	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?.....	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought?.....	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?.....	<input type="checkbox"/>	<input type="checkbox"/>	29. Ever had problems with homesickness?.....	<input type="checkbox"/>	<input type="checkbox"/>
15. Ever been diagnosed with a heart murmur?.....	<input type="checkbox"/>	<input type="checkbox"/>	30. Can the participant swim?.....	<input type="checkbox"/>	<input type="checkbox"/>
16. Ever had back problems?.....	<input type="checkbox"/>	<input type="checkbox"/>			
17. Ever had problems with joints (e.g. knees, ankles)?.....	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any “yes” answers, including dates where applicable, 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 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 nose
- 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
- Triple antibiotic (Neosporin), Sterile Wipes
- Insect repellent, Skeeter Stik, After Bite
- Benadryl tablet
- Sudafed
- Throat lozenges
- Sunscreen

CONSENT TO USE VOICE AND IMAGE

We respect and want to protect the privacy of our participants and staff. We, therefore, thought you would like to know that at some point during your attendance at a United Methodist mission trip, we might ask to photograph, videotape, film and/or interview you. We might do this because we believe that our participants and staff offer two great reasons to attend a United Methodist Mission trip, and we would like to be able to show you off by publishing in good taste some of the photographs, video, film and/or interviews for promotional purposes. To this end, the purpose of this document is to ask your permission in advance to capture your voice and image and possibly publish them in a United Methodist medium.

Accordingly, if you are willing to give us such permission, please read carefully and then execute this Consent to Use Voice and Image. If you are a participant or staff member age 18 or older, please sign the line over the designation "Signature of Adult participant or Staff Member." If you are a participant or staff member under age 18, one of your parents or your legal guardian must give us permission on your behalf by signing the line over the designation "Signature of Parent or Guardian of Minor participant or Staff Member."

By signing below I acknowledge and agree to the following:

1. I give my permission to the West Ohio Conference of the United Methodist Church and the Ohio River Valley District of United Methodist, including the owners, trustees, officers, employees, agents and volunteers of these entities, to photograph, videotape, film and/or interview me during my attendance at a United Methodist Camp for the purpose of promoting or reporting on the United Methodist Camps.
2. I, at any time, may decline to be photographed, videotaped, filmed and/or interviewed.
3. I give my permission to the West Ohio Conference of the Ohio river valley District of the United Methodist Church, including the owners, trustees, officers, employees, agents and volunteers of these entities, to publish any such photographs, video, film and/or interviews for the purpose of promoting or reporting on the United Methodist Camps. Further, I understand that publication may include, without limitation, use of any such photographs, video, film and/or interviews on United Methodist websites, brochures and/or videos dealing with the United Methodist Camps.

- Yes, I give permission for myself, (Adult Participant or Staff Member) or my child to be photographed
 No, I do not give permission for myself, (Adult Participant or Staff Member) or my child to be photographed

Signature of Parent or Guardian
of Minor Participant or Staff Member

Date

**(IF PARTICIPANT OR STAFF MEMBER IS
UNDER AGE 18)**

Signature of Adult Participant
or Staff Member

Date

**(IF PARTICIPANT OR STAFF MEMBER IS
AGE 18 OR OLDER)**

Screening Record (For Official Use Only)

Date screened _____ Time _____ am
_____ pm

Meds received? Yes (if yes, see additional page) No

Current health needs identified _____

Notes _____

Screened by _____