

CHRISTIAN FRIENDSHIP CAMP HEALTH FORM

For adults with developmental disabilities

Camp # _____

TO BE COMPLETED BY PARENT OR RESPONSIBLE AGENCY:

Name: _____ Birth date: _____ Age: _____ Sex: _____

Address: _____

Name of Parent(s)/Guardian(s): _____

Phone Numbers: Home _____ Work _____

If not available in emergency, please notify: _____

Phone Numbers: Home _____ Work _____

Name of present physician: _____ Phone: _____

Name of Dentist/Orthodontist: _____ Phone: _____

Has the camper had any of the following (if yes, give approximate date):

_____ Chicken Pox _____ Measles _____ German Measles
_____ Mumps _____ Diabetes(or Borderline) _____ Seizures (list date of last seizure)

List any recent exposures to contagious disease: _____

Does the camper have allergic reactions to any of the following:

_____ Penicillin _____ Other Drugs (specify) _____
_____ Pollens _____ Foods (specify) _____
_____ Bee Stings _____ Other (specify) _____

If "yes" to any of the above, please explain the severity of reaction: _____

Is the camper prone to any of the following:

_____ Frequent Colds _____ Athlete's Foot _____ Seizures
_____ Earaches _____ Fainting _____ Diabetes
_____ Bronchitis _____ Incontinence _____ Poison Ivy
_____ Heart Trouble _____ Bleeding/Clotting Disorders _____ Constipation
_____ Kidney Trouble _____ Emotional Disturbances _____ Sleep Walking
_____ Upset Stomach _____ Diarrhea _____ Asthma

Please describe in detail the nature of the problem(s) and the method of treatment: _____

Does the camper require any daily medication: _____ YES _____ NO

Please list all medications, include dosage and distribution times. Please attach an additional sheet if needed.

MEDICATIONS MUST BE BROUGHT IN THEIR ORIGINAL CONTAINERS WITH CAMPER'S NAME, NAME OF DRUG, DOSAGE, DOCTOR, PRESCRIPTION NUMBER, AND PHARMACY SUPPLYING DRUG. YOU MUST SEND AN ADEQUATE SUPPLY.

Are there any other health issues or behavioral issues the staff should know about? YES NO

If YES, explain: _____

Does the camper require a special diet? YES NO

If YES, explain: _____

Does the camper need attention in any of the following activities (if YES, explain):

- Dressing _____
- Eating _____
- Toileting _____
- Bathing _____
- Sleeping _____
- Swimming _____
- Other _____

IMMUNIZATION RECORD: please list dates of most recent booster.

****This is required by the State Department of Health****

_____ Measles _____ Rubella _____ Mumps _____ Tetanus
_____ Pertussis _____ Diphtheria _____ Polio

Has the camper had a physical by a doctor in the past two years? YES NO

If YES, give date and name of doctor: _____

If NO, please have one prior to camp and have a doctor fill out the Physician's Examination Form.

AUTHORIZATION FOR TREATMENT

IN AN EMERGENCY, I hereby give my permission to the licensed physician selected by the camp director to administer proper treatment and routine medical care, anesthesia, surgery, and hospitalization for persons named on this form, and to release necessary medical information for insurance purposes.

I also authorize the camp nurse to treat the camper as is determined necessary while at camp (e.g. "Tylenol").

Signature of Parent or Guardian Date

OTHER AUTHORIZATIONS

I hereby give my permission for Christian Friendship Camp to use photographs taken of this camper during his/her attendance at camp for the purpose of promoting this camp as sponsored by the United Methodist Camping Program.

Signature of Parent or Guardian Date

INSURANCE INFORMATION

CAMP INSURANCE COVERAGE is secondary to the camper's insurance policy. Camp insurance will help cover any deductible, prescriptions, and expenses in excess of your company's maximum coverage. (Please note that our coverage does not cover illness which is not specifically camp related, e.g. appendicitis or strep throat).

Policy Holders' Name: _____

Insurance Co.: _____ Policy #: _____