

# \*\*\*IMPORTANT\*\*\*

Camp # \_\_\_\_\_

## YOUTH Health History (for ages 0-17 years)

Please read the following information carefully. We are making every effort to provide the highest quality programming at camp. Sharing complete and accurate health information will allow us to provide the best experience possible for everyone involved.

We desire the very best for ALL campers.

### What is Required:

- **A physical exam every two years.** If you have had a physical exam in the last two years, please indicate the approximate date and the name of the doctor where indicated on health history form and complete the first three pages of this form. If not, please arrange to have one before camp begins, and have your physician fill out the back of the form. Most school activity exams qualify for this.
- A completed **Health History Form**. **THIS IS REQUIRED BY THE STATE LAW.** Please bring it with you to camp. Keeping a copy for your records is a good idea.
- **Camper's Immunization Record.** Campers **MUST** be immunized against the diseases indicated before they can come to camp. They should have had these immunizations for school. If, for some reason, they have not had them, please get them before time for camp and fill in the date of immunization. If a camper comes to camp without this information, they will be risking being sent home. All of our camps are responsible to the State of Minnesota Health Department regarding this matter.
- A camp staff member will be designated as the "health officer" for the week. He/she gives out the medication. **All Prescription Medication Must Be In Its Original Container.** A doctor is on call. A nearby clinic is utilized for occurrences beyond ordinary first aid procedures.
- **Parent Emergency Notification** – Concerning your camper; we will call in an emergency or if we have questions about their health or behavior, to the number indicated on their health history form. Please provide contact information for at least two alternates who know your child should we be unable to contact you.

Thank you in advance for your compliance with these health regulations.  
The Camp Minnesota Office, Minnesota Annual Conference, of the United Methodist Church

### Camper Contact Information

Name _____ Last First MI	Birth date _____
Address _____	Age _____
City _____ State _____ Zip _____	Gender _____

### Guardian Contact Information

Name of Parent(s)/Guardian(s) _____		
Work Phone ( ) _____	Home Phone ( ) _____	Cell Phone ( ) _____
<b>Alternative Contacts in case of emergency</b>		
Name _____	Phone ( ) _____	
Name _____	Phone ( ) _____	

# YOUTH CAMPER'S HEALTH HISTORY

You MUST bring this form with you to camp!

## Has your child had the following? (Y/N)

Chicken Pox                       Measles  
 German Measles                 Mumps

## Is your child prone to...

Frequent colds                       Earaches  
 Bronchitis                               Heart Trouble  
 Kidney trouble                       Upset stomach  
 Athlete's Foot                       Fainting  
 Bed wetting                               Constipation  
 Sleep walking                       Asthma  
 Seizures                                   Diabetes  
 Emotional disturbances               Poison Ivy  
 Bleeding/Clotting Disorders       Chest Pain  
 Eating Disorders                       NONE

## Has your child had...(Y/N)

An operation                       A serious injury  
 Exposure to a contagious disease

\*If yes to any please specify \_\_\_\_\_  
\_\_\_\_\_

## My child has been diagnosed as having...

ADD       ADHD       EBD  
 Other behavioral disorder       NONE

Please specify \_\_\_\_\_  
\_\_\_\_\_

## Does your child have any dietary restrictions?

(please list) \_\_\_\_\_  
\_\_\_\_\_

## Allergies

### Does your child suffer allergic reactions to the following?

Penicillin                               Latex  
 Bee stings                               None Known  
 Other Drugs (please specify) \_\_\_\_\_  
 Food (please specify) \_\_\_\_\_  
 Other (please specify) \_\_\_\_\_

Please describe the Reaction \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Immunization Record

### Please list dates of immunization or most recent booster

Measles \_\_\_\_\_                      Pertussis \_\_\_\_\_  
Rubella \_\_\_\_\_                      Diphtheria \_\_\_\_\_  
Tetanus \_\_\_\_\_                      Mumps \_\_\_\_\_  
Polio \_\_\_\_\_

## Medication(s) - Prescribed & Over-the-counter

### Does your child require any daily medication?

Yes                       No

If Yes, give name of medication(s) and dosage and when taken (camp health aid will administer) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Physical Examination

Has your child had a physical examination by a doctor in the past 2 years?       Yes       No

If YES, please list the date of the exam and the doctor who performed it.

Date \_\_\_\_\_                      Doctor \_\_\_\_\_

If NO, please have one before camp and have the doctor fill out the physician examination section of this form.

### Please list current Doctors:

Physician \_\_\_\_\_                      Phone (      ) \_\_\_\_\_  
Dentist/Orthodontist \_\_\_\_\_                      Phone (      ) \_\_\_\_\_

**IMPORTANT personal information needed from you?** Please provide any current information about the camper's behavior, physical, mental, emotional, or psychological health about which the camp should be aware OR conditions that require medication, treatment, or special restrictions or considerations while at camp. We have particular interest in information which has impact upon your child's ability to participate fully in our program. (Please SEE Camper Participation authorization below - use additional sheets if need)

**1. My child will be attending:**

Campsite \_\_\_\_\_

Dates of Camp \_\_\_\_\_

Name of Camp \_\_\_\_\_

Camp Number \_\_\_\_\_

**2. I understand that videos/photos taken of my child at camp may be used by the Minnesota Annual Conference for promoting and publicizing camping. I give my permission for this.**

Yes \_\_\_ No \_\_\_

**3. I will not be able to pick up my child from camp. The following person is authorized to pick up my child from camp.** (leave blank if you will be picking up your child).

\_\_\_\_\_ Name

\_\_\_\_\_ Phone Number

(Please notify camp if this information changes)

**Insurance**

**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 #** \_\_\_\_\_

**Prescription Benefits** \_\_\_\_\_

**\*\*\*CAMPER PARTICIPATION & AUTHORIZATION FOR TREATMENT\*\*\***

**PARTICIPANT PERMISSION:** My child, described herein, has permission to engage in all prescribed camp activities except as noted by me and/or an examining physician. I understand that camp activities can be strenuous and that some activities involve a risk of accidents which may result in serious bodily injury or harm to my child (e.g. swimming, canoeing, field sports, hiking, biking team building activities, transportation by camp vehicle, and other normal camp activities). Additional information on specific activities can be found in camp brochure and deans letter. For all activities deemed outside the normal camp experience, parents will be informed and special permission requested (i.e. horseback riding, high ropes, water skiing, etc.)

**Activities this camper should be exempted from:** \_\_\_\_\_

**AUTHORIZATION FOR TREATMENT**

I authorize the camp nurse and/or health supervisor to treat my child as they determine is necessary while at camp. (e.g. Over-the-Counter Medications)

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 my child named on this form and to release necessary medical information for insurance purposes. I further authorize the camp health officer access to test results, diagnoses, and treatment plan (limited only to the time my child is at camp) in order to best care for him/her and others at the camp.

**X**

\_\_\_\_\_ Signature parent/guardian

\_\_\_\_\_ Date

**THIS MUST BE SIGNED AND DATED FOR YOUR CHILD TO PARTICIPATE IN CAMP!**

\_\_\_\_\_ Over for Physicians Examination Form \_\_\_\_\_

Summer Camping Program  
Minnesota Annual Conference  
The United Methodist Church

**\*\*\*PHYSICIANS EXAMINATION FORM\*\*\***

Note: Please have your doctor complete this page only  
if you have not had a physical within the past 2 years.

**TO BE COMPLETED BY PARENTS**

Campers Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**TO BE COMPLETED BY PHYSICIAN**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Posture(spine) \_\_\_\_\_  
Eyes \_\_\_\_\_ Ears \_\_\_\_\_  
Nose \_\_\_\_\_ Throat \_\_\_\_\_  
Teeth \_\_\_\_\_ Heart \_\_\_\_\_  
Lungs \_\_\_\_\_ Abdomen \_\_\_\_\_

Menstrual history, if applicable \_\_\_\_\_  
Comments, special problems, allergies, etc. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications (type and dosage) the camper will be taking at camp:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have examined the person named herein and believe at this time she/he is in satisfactory condition and may engage in all usual camp activities unless otherwise indicated below as restricted or exempted.

Restricted or exempted activities to include: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signed: \_\_\_\_\_ M.D.

Physicians address \_\_\_\_\_

Telephone Number \_\_\_\_\_ Date of Examination \_\_\_\_\_

**TO BE FILLED IN BY CAMP HEALTH SUPERVISOR**

List routine treatment required during camp period: for example, further examination, special food, or injections:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Record of illness or accident	COMMENT	TREATMENT
DATE: _____	_____	_____
_____	_____	_____
_____	_____	_____

Conditions arising in camp which should be called to the attention of the parents/guardians: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Record medical reimbursement claims: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Camp Health Supervisor \_\_\_\_\_ Date \_\_\_\_\_