

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 only the front side 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. If possible, please complete this form and return it to the camping office at least 2 weeks prior to the start of camp. Otherwise, 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 you compliance with these health regulations.
The Camping 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 () _____	
Alternative Contacts in case of emergency	
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

INSURANCE COVERAGE is for expenses over and above those covered by a family's insurance policy. There should be NO out-of-pocket expenses for those incidents that are camp-related. Camp insurance will 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 #** _____

*****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!

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

DATE: _____	COMMENT	TREATMENT
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 _____