Camper Name ____Camp Name ____________________________ Event #______________

Please fill in information above

HEALTH FORM FOR UNITED METHODIST CAMPS, NEW YORK CONFERENCE

IMPORTANT: This form must be filled out **completely on both sides prior** to the summer event(s), signed by the person(s) indicated, and mailed **before** the event. The form may be brought to camp during event registration; however, if the Health Form is not properly completed and signed, the camper will be unable to complete registration. Participants under age 19 must have a parent/guardian sign the completed form.

PARTICIPANT NAME ____ D.O.B. ______________ AGE_______ GENDER _______ EVENT #________

PARENT/GUARDIAN/SPOUSE/CASEWORKER __________________________________ HOME PH: ___________________ DAYTIME PH:________________

ADDRESS ____ CITY _______________________ STATE _______ ZIP _____________

1st EMERGENCY CONTACT ____ RELATIONSHIP________________________ PH # _______________

2nd EMERGENCY CONTACT____ RELATIONSHIP ________________________ PH# _______________

PHYSICIAN NAME: ____ PH # __________________________________

Is the participant covered by family medical/hospital insurance? YES NO If "yes", please list carrier or plan name:________________________________

Policy #__________________________________ Group # _________________

Photocopy of front and back of health insurance card must be attached to this form.

IMPORTANT: The box below must be completed for attendance

Parent/Guardian Authorizations: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted. I give permission to the camp to arrange for necessary related transportation for me/my child. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

I hereby give permission to the camp to provide routine health care and seek emergency medical treatment including ordering x–rays or routine tests. I give permission for the camp health care provider to dispense prescription and non–prescription medications to me/my child which are approved by a physician, brought with the participant and/or are indicated in standing orders approved by a physician.

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 person named above. I affirm that the camp, its staff and volunteers are held harmless from any liability claims, judgments and costs incurred during my/my child's stay at the facility or involvement in the camp experience. This completed form may be photocopied for trips out of camp.

*Signature of parent/guardian or adult camper/staff:*____

Printed name: ____ *Date:*____

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor or adult camper/staff: ____ *Date:* ____

Health Form continues on the back. Please complete all sections.

IS PRESCRIPTION OR OVER–THE–COUNTER MEDICATION BEING SENT TO CAMP? (circle one) YES NO
IF YES, you must complete the MEDICATION INFORMATION RELEASE FORM.

HEALTH HISTORY: *The following must be completed by parent/guardian, or adult camper or staff member This information provides the camp health care personnel with the background necessary to provide appropriate care. Please provide complete information so that the camp can be aware of your needs. Mark all information and explain "yes" responses below.*

	yes	no		yes	no		yes	no		yes	no		yes	no
Frequent ear infections			Recent injury or illness			Ever had surgery?			Eating disorder			HIV / AIDS		
Chronic or recurring illness/condition			Mononucleosis in past 12 months?			If female, any abnormal menstrual history?			Wear glasses, contacts, protective eyewear			Emotional difficulties for which professional help was sought?		
Convulsions/seizures			Heart disease/defect			Ever hospitalized?			Joint problems (knees, ankles, etc.)			Hypertension		
Diabetes			Head injury			Poison ivy, etc.			Bed wetting			Sleep walking		
Bleeding/clot disorder			Chest pain			Hay fever			Asthma			ADD/ADHD		

HEALTH HISTORY: *Please explain all "yes" responses.* ______________________________

____

____

ALLERGIES:

List all known allergies

Describe reaction and management of reaction

Medication allergies

______________ ______________________________

______________ ______________________________

______________ ______________________________

Food allergies

______________ ______________________________

______________ ______________________________

Other allergies--include insect stings, asthma, hay fever, etc.

______________ ______________________________

______________ ______________________________

______________ ______________________________

DIETARY RESTRICTIONS

- ☐ Does not eat dairy products
- ☐ Does not eat red meat
- ☐ Does not eat seafood
- ☐ Does not eat eggs
- ☐ Restrictions on sugar or food dyes *(describe):*

____

- ☐ Other dietary restrictions *(describe):*

____

CAMPER/PARTICIPANT NAME: ______________________________

IMMUNIZATIONS: Please give dates for all immunizations, including the month and year for each.

Vaccine & Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	_____	_____	_____	_____	_____	_____
Tetanus/Diptheria	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	
MMR	_____	_____				
or Measles	_____	_____				
or Mumps	_____	_____				
or Rubella	_____	_____				
Hepatitis B	_____	_____	_____			
Varicella	_____	_____				
Haemophilus Influenza Type B	_____	_____	_____	_____		

Which of the following has the participant had?

- ❑ Measles
- ❑ Chicken pox
- ❑ German measles
- ❑ Mumps
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C

TB Mantoux Test
Date of last test: ______________________
Result: ______________________________

THIS BOX IS TO BE COMPLETED AND SIGNED BY A LICENSED HEALTH CARE PROFESSIONAL

I have examined the above applicant within the past two (2) years (circle one): YES NO Date of examination: ______________________

Height: ___________ Weight: ____________ Blood pressure: ______________________

In my opinion, the applicant (check one) is _________ is not ___________ able to participate in an active camp program.

Are any medications to be administered at camp (circle one) : NO YES Also please complete MEDICATION INFORMATION RELEASE FORM.

Description of any limitation or restriction on camp activities: ______________________________

Additional information for health care staff at the camp: ______________________________

Signature of licensed medical personnel: ______________________________ ***Date:*** ______________

Print name: ______________________________ ***Title:*** ______________

Office Address: ______________________________ ***Office Phone:*** ______________

INDIVIDUALIZED STANDING ORDERS
Medication Information and Release

Name of Camper: ______________________ DOB __________________ Weight _______

To Physicians: We know how valuable your time is and know that you also appreciate the increasing complexities we are facing at camp in dealing with camper's medical needs. We would appreciate your filling out this form to facilitate the treatment of our camper who is your patient. Below lists typical medications for which we have standing orders from our local physician. Please indicate the medications you would want (or not want) dispensed by our medical staff to the camper if needed. Please complete in the spaces provided for all medications the camper will bring to camp including prescriptions and over the counter medications. Thank you for helping us with the completion of this form.

Drug Name	Route	Dosage	Schedule and indications	Health Care provider order	Comments
Tylenol		Per label instructions by age-weight	Q 4 hr prn for pain or fever >______ ?F	Yes No	
Ibuprofen		Per label instructions by age-weight	Q 6 hr prn for pain or fever >______ ?F	Yes No	
Robitussin		Per label instructions by age-weight	Q 4 hr prn for cough	Yes No	
Pepto-Bismol		Per label instructions by age-weight	Q 30 min to 1 hr prn for diarrhea (no>8 doses/24 hr)	Yes No	
Children's Mylanta		Per label instructions by age- weight	BID-TID prn for stomach upset	Yes No	
Dramamine		Per label instructions by age-weight	Q6-8 hrs prn for motion sickness	Yes No	
Dimetapp		Per label instructions by age/weight	Q 6-8 hr prn for nasal congestion /drainage	Yes No	

Drug Name	Route	Dosage	Schedule and indications	Health Care provider order	Comments
				Yes No	
				Yes No	
				Yes No	

Physician please Initial_____________ Date ___________

Note to parents: Any medications (prescription or over the counter) your child brings to camp must be given to the camp health care staff at registration and must be in the original packaging with the following information on it:
Name of medication Name of person to receive the medication Expiration date Name of Physician (for prescripton medications only) Directions for dispensing
Please place all medications for a given camper in a zip lock type bag with the camper's name on the bag and be sure that each medication is listed. Prescription Medications -Please complete with patient's current regimenfor both scheduled and prn medications in the space above.

Signature of parent or guardian ____________________________ Date __________