HEALTH HISTORY AND EXAMINATION FORM FOR CHILDREN ATTENDING CAMP

Aldersgate Camp & Retreat Center

SECTION 1: Camper Information **(to be completed by parent/guardian of camper)**

Name _____ Birth Date _____ Age at Camp ____ Gender: ☐ Male ☐ Female
Last First Middle

Home Address _____
Street Address City State Zip

Custodial Parent/Guardian_____ Home Phone _____

Cell Phone _____Business Phone _____

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

If parent is not available, list emergency contact_____

Relationship _____ Home Phone _____ Cell Phone _____

Address _____
Street Address City State Zip

SECTION 2: Insurance Information **(to be completed by parent/guardian of camper)**

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No If so, health insurance carrier

_____ Policy # _____

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

Important – The following box must be complete for attendance:

I hereby authorize the Camp Director and staff to act for me, and on my behalf, according to their best judgment, in any emergency requiring medical attention to be administered to my child, until such time as I may be contacted. I give permission for a Aldersgate Camp & Retreat Center first-aider, or other designated camp staff member, to administer authorized medication and/or first aid and/or emergency treatment to my child during the camp session. It is understood that if time and circumstances permit, the Camp Director will endeavor, but is not required, to contact me prior to the rendering of medical care to my child for which consent is given pursuant to this authorization. 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. I also agree to the release of any of my camper's records necessary for treatment, referral, billing or insurance purposes.

I understand and agree that Aldersgate Camp & Retreat Center shall not be legally or financially liable for any claim arising from the medical care provided pursuant to this authorization. I hereby assume full responsibility for payment of any medical treatment or related services incurred in connection with such emergency. I hereby agree to indemnify and to hold Aldersgate Camp & Retreat Center harmless from any claim made by or on behalf of any individual or entity providing medical care to my child pursuant to this authorization.

If my child is injured while participating at Aldersgate Camp & Retreat Center, whether at the camp or away, I and my child agree to waive any legal claim against Aldersgate Camp & Retreat Center, the staff and volunteer personnel operating the camp. This authorization is given to Aldersgate Camp & Retreat Center for use in conjunction with any activity conducted by Aldersgate Camp & Retreat Center including transportation to/from the activity and shall be valid until revoked in writing from the undersigned. I hereby give permission for my child to leave Aldersgate Camp & Retreat Center for prescribed activities. I, and my child, further waive, release, and discharge Aldersgate Camp & Retreat Center, its staff, agents, representatives, employees, and assigns of and from any and all rights and claims from damages resulting from injury or property which may be sustained or occur during camp activities, or arising from travel to or from camp.

Signature of parent/guardian _____ Date _____

Printed Name _____

SECTION 3: Health History **(to be completed by parent/guardian of camper)** Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

Immunizations (dates): DPT/DT/DTAP 1)_____ 2)_____ 3)_____ booster year(s) 1)_____ 2)_____ ;
Tetanus _____ (tetanus **must** be up to date before attending camp); polio series_____ last polio booster_____; measles_____;
mumps_____; rubella_____; HIB_____; Hepatitis B_____

Allergies (list all known) Describe reaction and management of the reaction. _____

_____

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.

☐ **This camper 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 _____

Attach additional pages for more medications.

☐ This camper takes NO medications on a routine basis.

List any **dietary** restrictions that apply to this camper: _____

_____

List any **physical** restrictions and explain: _____

Print the name of your family physician _____ Phone _____

Date of last physical _____

Print the name of your family dentist/orthodontist _____ Phone _____

HEALTH CARE RECOMMENDATIONS TO BE COMPLETED BY LICENSED MEDICAL PERSONNEL

I examined this individual on _____ (Must be within 12 months of camp attendance.)

BP _____ Weight _____ Height _____

In my opinion, the above applicant ☐ is ☐ is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions: _____

_____

_____

Treatment/medications to be administered/continued at camp: _____

_____

Description of any limitations or restrictions at camp (dietary or physical): _____

_____

Additional information for health care staff at the camp: _____

Signature of Licensed Medical Personnel _____

Printed Name_____ Title _____

Address _____

Phone _____ Date _____