HEALTH HISTORY AND EXAMINATION FORM FOR CAMPERS ATTENDING

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

Home Address _____
Street Address *City* *State* *Zip*

Custodial Parent/Guardian_____ Home Phone _____

Cell Phone _____Work Phone _____

Home Address _____
Street Address *City* *State* *Zip*

If parent is not available, list emergency contact_____

Relationship _____ Home Phone _____ Cell Phone _____

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 # _____ Group #_____

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

Important – The following box must be complete for attendance:

In signing this application, I certify that all information provided to Aldersgate Camp & Retreat Center is correct. I certify that my child is in good physical health and I give permission and consent for my child to participate in any and all camp activities.

I understand that my child may be transported in a camp vehicle. This completed form may be copied for off-site travel.

I understand that children at camp can become ill or have an injury and need medical attention. I give permission to the camp Health Care Provider to give over the counter medication (such as Tylenol, etc.) to my child as proper treatment as deemed necessary for minor ailments.
In case of medical emergency. I give permission for the release of medical records for insurance purposes. I give permission to the physician, nurse, hospital, etc. selected by the Camp Director (or his representative) to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child. I agree to submit my insurance claims to my insurance carrier first and will only use camp's insurance plan as a secondary insurance.

I understand that the nature of outdoor camping ministries includes some risk of injury or death and that children at camp can injure themselves without fault on the part of camp personnel. I release Aldersgate Camp & Retreat Center, the Kentucky Annual Conference of the United Methodist Church and their representatives from responsibility for injury to my child.

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 (most recent date): Chicken Pox (Varicella)_____; DTap, DTP or DT (Diptheria, Pertussis, Tetanus) _____ ; Hepatitis A _____; Hepatitis B_____; MMR_____; Hib_____; PCV (Pneumococcal)_____ Meningococcal (MCV4)_____; TB_____; HPV _____

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: _____

Your family doctor _____ Phone _____
Date of last physical _____

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 _____