Health History Form

ELCA East Bay Camp

camper last name:

_____

first name

_____

CAMPER/FAMILY INFO:

Camper Name:_____ Birthdate:_____/_____/_____
Last First MI

Gender: M F Age at time of camp:_____ Mailing Address:_____
Street Address City State Zip

Parent or Guardian:_____ Home Phone:(_____)_____

Address (if different from above):_____
Street Address City State Zip

Work Phone:(_____)_____ Cell Phone:(_____)_____ Email:_____

Please provide a valid, legible e-mail address – required release forms will be received via e-mail

EMERGENCY CONTACT:

Please check here if you ***do not*** have an e-mail address: ☐

Contact the following person in an emergency if parent or guardian above is not available:

Name:_____ Relation to camper:_____
Last First

Home Phone:(___)_____ Work Phone:(___)_____ Cell Phone:(___)_____

HEALTH HISTORY:

Physician Name:_____ Address/Phone_____(___)_____
Street City State Zip Phone

Any known allergies: □ Yes □ No

To medications:_____

Food allergies:_____

Other allergies:_____

Dietary restrictions (due to medical conditions):_____

(Check below all that apply)

☐ Asthma ☐ Epilepsy/Convulsions/Seizures ☐ Frequent Ear Infections ☐ Frequent sore throats

☐ Frequent Stomach Upset ☐ Frequent Sore Throats and/or Colds ☐ Fainting ☐ Glasses ☐ Headaches

☐ Bed-Wetting ☐ Hearing Aid ☐ High Blood Pressure ☐ Heart Disease ☐ Back Problems

☐ Problems with Joints ☐ Menstrual Problems ☐ Alcohol/drug addiction ☐ ADD/ADHD ☐ Diabetic

☐ Other:_____ Pertinent medical treatment:_____

Is camper taking or using any type of medication(s) or drug(s)? □ Yes □ No

If yes, please list:_____

Is camper current on all immunizations as required by the public school system? □ Yes □ No Date of last Tetanus shot: _____/____/_____

Does the camper have a health condition (e.g. allergies, chronic conditions) or special circumstances which may affect program participation, special housing needs, or anything we ought to know prior to emergency treatment? □ Yes □ No

If yes, please explain:_____

Please complete the other side of this form

PERMISSION TO ADMINISTER MEDICATIONS:

camper last name:

_____

first name:

_____

I, the (parent/guardian/camp participant) of
Please circle which

_____, give permission to the camp Health Care Provider or his/her designate to give the following medications (or the generic equivalents) to the camper listed above, in accordance with recommended package dosing for the specific indications below. These medications are available at camp and need not be brought by participants.

	Yes	No		Yes	No
Tylenol: Mild fever or discomforts	□	□	Benadryl: Allergy symptoms	□	□
Ibuprofen: Mild fever or discomforts	□	□	Sudafed: Allergy symptoms	□	□
Throat Lozenges: Coughs/sore throat	□	□	Antacid: Upset stomach	□	□
Topical Creams: Itching, sunburn, or insect bites	□	□	Anti-diarrheal: For diarrhea	□	□
Permission to follow recommendations by local Poison Control Centers	□	□			

Signature of Parent/Guardian/Self:_____ Date:_____/_____/_____

Note: The camp personnel will notify you or the emergency contact if you or your child displays the following symptoms:

- ☐ Any illness that persists longer than 24 hours; including fevers, coughs, excess expulsion of bodily fluids, allergic reactions, severe tiredness.
- ☐ Any injury that causes severe prolonged pain, discoloration and/or swelling.
- ☐ Any condition that cannot be sufficiently treated by camp personnel.
- ☐ Any condition requiring transportation to other medical services.

FAMILY MEDICAL INSURANCE:

Family Medical Insurance □ Yes □ No Name of Policyholder:_____
Individual's First and Last Name

Guarantor:_____ Group Number:_____ Policy Number:_____

Parent/Guardian/Participant Authorization:

I,_____, represent that the above information is correct for either me or my child. I or my child has permission to take part in all camp activities under supervision unless limitations are noted above, and I agree that the camp or camp personnel will not be held responsible for accidents arising therefrom. I hereby give permission to the camp to provide medical health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me or my child. In the event of an emergency: (for child) if I cannot be reached, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, injection, surgery and anesthesia for the person named above; (for myself) and in which I am incapacitated and/or the emergency contact can not be reached, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, injection, surgery and anesthesia for the person named above. This completed health form may be photocopied for trips out of camp. My signature below represents that the above information on this form is correct for the camper listed.

Signature of Parent/Guardian:_____ Date:_____