IGRC United Methodist Camps

Health History Form

This completed form (front and back) **must** be sent to the address listed below to ensure confirmation of camp.

Camper Last Name, First Name ______________________

Name of Camp & Number ______________________

Dates of Camp ______________________

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

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

EMERGENCY CONTACT:

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:____

PERMISSION TO ADMINISTER MEDICATIONS:

Camper Last Name, First Name
Name of Camp & Number
Dates of Camp

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
Tylenol: Mild fever or discomforts	☐	☐
Ibuprofen: Mild fever or discomforts	☐	☐
Throat Lozenges: Coughs/sore throat	☐	☐
Topical Creams: Itching, sunburn, or insect bites	☐	☐
Permission to follow recommendations by local Poison Control Centers	☐	☐
Benadryl: Allergy symptoms	☐	☐
Sudafed: Allergy symptoms	☐	☐
Antacid: Upset stomach	☐	☐
Anti-diarrheal: For diarrhea	☐	☐

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:___________________

<u>Parent/Guardian/Participant Authorization:</u>

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:______________________________

Fax 217.529.4150 ● PO Box 19207, Springfield, IL 62794-9207 ● Phone 217.529.3007