

**Camper Health History & Authorization
Iowa Annual Conference of the
United Methodist Church**



**Please bring this
completed form to
camper check-in**

This form is **MANDATORY** and must be completed by the legal guardian of any minor participant, as well as all adult participants, attending camping events. This form is **REQUIRED** at the time of camper check-in and the "Camp Authorization" and "Public Relations Release" (back page) **MUST** be signed.

Okoboji • Pictured Rocks • Wesley Woods

Name of Participant: _____ Birth Date: _____ Grade completed: _____
(last) (first) (middle)

Home address: _____
(Street address) (City) (State) (Zip)

Participant Social Security Number: _____ Gender: Male Female

Custodial parent/guardian: _____

Home address: _____
(if different) (Street address) (City) (State) (Zip)

Home phone: _(____)_____ Work Phone: _(____)_____ Cell or other phone: _(____)_____

Other custodial parent/guardian: _____

Home address: _____
(if different) (Street address) (City) (State) (Zip)

Home phone: _(____)_____ Work Phone: _(____)_____ Cell or other phone: _(____)_____

If not available in an emergency, please contact: _____

Relationship: _____ Phone: _(____)_____

Address: _____
(Street address) (City) (State) (Zip)

INSURANCE INFORMATION – Please attach a copy of the front and back of health insurance card

Is the participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name: _____ Group #: _____

Date of birth of policy holder: _____ Social Security # of policy holder: _____

Diet, Nutrition:

- This camper eats a regular diet This camper eats a regular vegetarian diet
 This camper has special food needs (please describe below)

Restrictions:

- I have reviewed the program/activities of the camp and feel that the camper can participate without restrictions
 I have reviewed the program/activities of the camp and feel that the camper can participate with the following restrictions (please describe below)

Allergies:

- No known allergies
- The camper is allergic to:
 - Food
 - Other
 - Medicine
 - The environment (insects, hay fever, etc.)

(please describe below what the camper is allergic to and the reaction seen)

MEDICATIONS BEING TAKEN - "Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. All medications are collected, stored, and distributed by camp health care personnel. Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely.

Bring only enough medications 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 will not take any daily medications while attending camp
- This camper will take the following daily medication(s) while at camp:

Med #1 _____	Dosage _____	Specific times taken _____
Reason for taking _____		
Med #2 _____	Dosage _____	Specific times taken _____
Reason for taking _____		
Med #3 _____	Dosage _____	Specific times taken _____
Reason for taking _____		
Med #4 _____	Dosage _____	Specific times taken _____
Reason for taking _____		
Med #5 _____	Dosage _____	Specific times taken _____
Reason for taking _____		

- Camp staff has permission to administer **over-the-counter** medications as necessary.

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. **Cross out those the camper should not be given.**

- | | |
|--|---|
| <ul style="list-style-type: none"> Acetaminophen (Tylenol) Phenylephrine decongestant (Sudafed PE) Antihistamine/allergy medicine Diphenhydramine antihistamine/allergy medicine (Benadryl) Sore throat spray Lice shampoo or cream (Nix or Elimate) Calamine lotion Laxatives for constipation (Ex-Lax) | <ul style="list-style-type: none"> Ibuprofen (Advil, Motrin) Pseudoephedrine decongestant (Sudafed) Guaifenesin cough syrup (Robitussin) Dextromethorphan cough syrup (Robitussin DM) Generic cough drops Antibiotic cream Aloe Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol) |
|--|---|

Pill Count:

Med #1 _____	In _____	Out _____
Med #2 _____	In _____	Out _____
Med #3 _____	In _____	Out _____
Med #4 _____	In _____	Out _____
Med #5 _____	In _____	Out _____
<u>Camper Check-in</u>		<u>Camper Check-out</u>
Staff Initials at check-in _____	_____	Staff Initials at check-out _____
Parent/Guardian Initials at check-in _____	_____	Parent/Guardian Initials at check-out _____

GENERAL QUESTIONS – please explain “YES” answers below:

Has/does the participant:		YES	NO		YES	NO	
1.	Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	11.	Had fainting or dizziness?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	12.	Passed out/had chest pain during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Have recurrent/chronic illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	13.	Had mononucleosis ("mono") during the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Had a recent infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	14.	If female, have problems with periods/menstruation?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Had a recent injury?	<input type="checkbox"/>	<input type="checkbox"/>	15.	Have problems with falling asleep/sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Had asthma/wheezing/shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	16.	Ever had back/joint problems?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	17.	Have a history of bedwetting?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	18.	Have problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Had headaches?	<input type="checkbox"/>	<input type="checkbox"/>	19.	Have any skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
10.	Wear glasses, contacts, or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>	20.	Traveled outside the country in the past 9 months?	<input type="checkbox"/>	<input type="checkbox"/>

Please explain “YES” answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

Mental, Emotional and Social Health – check “YES” or “No” for each statement:

Has the camper:

- | | | | | |
|--|--------------------------|-----|--------------------------|----|
| 1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 2. Ever been treated for emotional or behavioral difficulties or an eating disorder? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 3. During the past 12 months, seen a professional to address mental/emotional health concerns? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 4. Had a significant life event that continues to affect the camper’s life | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain “Yes” answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Which of the following has the participant had?

- | | | |
|---|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hepatitis A | |
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Hepatitis B | |

TB Mantoux Test

Date: _____

Result: Positive Negative

Immunization History:

Are the participants immunizations/vaccinations up to date? Yes No

Date of last Tetanus shot: _____

Name of Physician: _____ Phone:_(_____)_____

Address: _____

Name of Dentist/Orthodontist: _____ Phone:_(_____)_____

Address: _____

DATE OF LAST HEALTH EXAM: _____

YOU WILL BE CONTACTED IF:

- Your child is exposed to a communicable disease
- Outside medical attention is necessary (e.g., if we transport your child to a hospital/Dr. Office)
- Your child is having discipline problems that jeopardize the safety of others

What Have We Forgotten to Ask? Please provide in the space below any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. **Attach additional information if needed.**

CAMP AUTHORIZATION

The undersigned person represents that he/she is the custodial parent/legal guardian of the above identified participant. The Camper has my/our permission to attend the camping session from _____ to _____ (dates) at Camp _____ (Site Name). This permission is given by me/us with full knowledge of the conditions and activities contemplated during each session (see conference camping catalog and/or site brochure for details). The participant has no physical or mental disabilities that would impair their participation except as noted above. I/We acknowledge, agree to, reconfirm and incorporate herein by reference the Release of Liability signed by me/us which is attached hereto. I also understand that the information provided on this form will be kept confidential and shared only as necessary to provide care for the participant.

I understand that camp insurance is a supplemental policy only. It will pay whatever my own insurance doesn't cover (deductible or over) up to the limit of the policy. If medical (sickness, injury) care is needed, billings will be sent to the parent/guardian who will be responsible for direct payments to physician, hospital, clinic, etc...

The participant is currently taking only medications listed above. The camper has no allergies known to me/us except as noted on this form. The health information/history is correct as far as I/we know. In the event of illness or injury, I/we authorize the camp, physician and/or hospital to undertake such treatment of and perform such services (including surgical) for the participant as are reasonably indicated by the circumstances.

Signature of LEGAL Parent/Guardian or Adult _____ Date: _____

Signature of 2nd LEGAL Parent/Guardian _____ Date: _____

My child will be riding home with _____ Phone#: _____

PUBLIC RELATIONS RELEASE

United Methodist Camp personnel may at their discretion, elect to include photographs of persons and events at United Methodist Camps in printed materials, news releases, film presentations, authorized camp or conference websites and the like for the purpose of advancing the mission of the United Methodist Camp program. I hereby give permission for photo or visual image of the above named individual to be used for such purposes, without compensation or prior approval rights, at any time with the understanding that said individual will not be identified by name, without permission.

Parent/Guardian of Minor Participant
or Minor Staff Member

Date

Adult Participant
or Staff Member

Date

Yes	No		Yes	No		Staff use only
<input type="checkbox"/>	<input type="checkbox"/>	Recent exposure to communicable disease, illness, injury?	<input type="checkbox"/>	<input type="checkbox"/>	Any allergies?	
<input type="checkbox"/>	<input type="checkbox"/>	Consent sections filled out, signed and complete?	<input type="checkbox"/>	<input type="checkbox"/>	Meds. Checked in, pill counts documented?	
<input type="checkbox"/>	<input type="checkbox"/>	Anything that requires follow-up?	<input type="checkbox"/>	<input type="checkbox"/>	All info. current & complete?	
Staff Initials _____		Date _____				