Central Pacific Conference, United Church of Christ

Camp Adams/Pilgrim Cove

HEALTH FORM

Campers name________________________Age______Birthdate________ Gender_____
Address____
Street City State Zip
Parents name________________________Telephone numbers__________ __________
Home/cell work
In case of emergency, please contact:
Name:________________________Phone#(____)_______________Relationship_______
Name:________________________Phone#(____)_______________Relationship_______

Name of Medical Insurance Carrier ___________________ Policy#___________________
Please attach a copy of the front and back of the camper's insurance card.

HEALTH HISTORY

Yes	No	Condition		Explain
____	____	Asthma	Last attack_______	______________________________
____	____	Diabetes	Last BbA1c_______	______________________________
____	____	Hypertension		______________________________
____	____	Heart Problem		______________________________
____	____	Lung/respiratory disease		______________________________
____	____	Ear/Sinus Problem		______________________________
____	____	Muscular/skeletal condition		______________________________
____	____	Menstrual problems		______________________________
____	____	Psychiatric/emotional difficulties		______________________________
____	____	Bleeding disorder		______________________________
____	____	Fainting Spells		______________________________
____	____	Thyroid disease		______________________________
____	____	Kidney disease		______________________________
____	____	Seizures	last seizure____	______________________________
____	____	Sleep disorders		______________________________
____	____	Abdominal/digestive problems		______________________________
____	____	Surgery		______________________________
____	____	Serious injury		______________________________
____	____	Other		______________________________

Is the camper sensitive to bee strings?______If so, how should the camper be treated if stung?

Allergies? Medication___________________ Food ______________________
Other__________________________
List any dietary restriction________________________ Vegetarian? ________________
Date of last Tetanus Booster _______________________

I give permission for over the counter treatments to be given to my child. (Tylenol, Ibuprofen, Topical creams, Allergy medication, Antacid, Anti-diarrheal, Cold medicine)Yes ___________ No _________

Please provide any information you feel will help us help the camper have a successful camp experience. ____
____

Current Health:
Does the camper take medication regularly? Yes___ No ____. Will the camper take medication while at camp? Yes _____ No _____
Please list all prescription and over the counter medications.
Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

1. ________________________ Dosage_______________
2. ________________________ Dosage_______________
3. _________________________ Dosage______________
4. _________________________ Dosage ______________

Please bring enough medication to last the entire time at camp.

ALL MEDICATION BROUGHT TO CAMP MUST BE IN ORIGINAL CONTAINERS

PARENT/GUARDIAN AUTHORIZATION

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 there from. I hereby give permission to the camp to provide routine health care, administer prescribed and over the counter medications and seek emergency medical treatment. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation to my child.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment including hospitalization, for the person named above. This completed health form may be photocopied for trips out of camp.

____
Signature of parent/guardian Date