

Camper Health History & Authorization Form

Camp Minnesota
A Ministry of the MN Annual Conference of the United Methodist Church



Event # _____

Please bring this completed form to camper check-in or complete online at least 2 weeks prior to camp.

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

Koronis Ministries • Northern Pines • Kowakan Adventures • Off Site

General Information	Participant:	Name (last, first, middle):		
		Birth Date:	Grade Completed:	
		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		
		Home Address:		
	Parent/Guardian with legal custody to be contacted in case of illness or injury:	Name:		Relationship to camper:
		Home Address (if different from above):		
		Preferred Phones: ()		()
		Email address:		
	Second parent/guardian or other emergency contact:	Name:		Relationship to camper:
		Preferred Phones: ()		()
		Email address:		
	Additional contact in event parent(s)/guardian(s) cannot be reached:	Name:		Relationship to camper:
Preferred Phones: ()		()		
Email address:				

Insurance Information	Please bring a copy of the front and back of health insurance card to camp	
	Is the participant covered by family medical/hospital insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If so, indicate carrier or plan name:	
	Policy or Group #:	
	Policy holder name:	

Allergy Information	<input type="checkbox"/> No known allergies	
	The camper is allergic to:	Please describe what the camper is allergic to, the reaction seen, and how it is treated:
	<input type="checkbox"/> Food(s)	
	<input type="checkbox"/> Medicine(s)	
	<input type="checkbox"/> The environment (insects, hay fever, etc.)	
	<input type="checkbox"/> Other	

Diet/Nutrition Information	<input type="checkbox"/> This camper eats a regular diet
	<input type="checkbox"/> This camper eats a regular vegetarian diet
	<input type="checkbox"/> This camper has special food needs (please describe):

Medication Information (Use additional pages as necessary)	<p>"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.</p>							
	<input type="checkbox"/> This camper will not take any daily medications while attending camp							
	<input type="checkbox"/> This camper will take the following daily medication(s) while at camp:							
	Name of Medication:	Reason for taking:	Times Given:	Amount/Dose Given:	How dose is given:	Pill Count:		Initials: <i>(guardian and staff)</i>
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other:			In:		
	Original Start Date: (mm/yyyy):					Out:		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other:			In:		
	Original Start Date: (mm/yyyy):					Out:		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other:			In:		
	Original Start Date: (mm/yyyy):					Out:		
Staff / Volunteers Only – Do you require any medication that might impair your ability to perform the essential functions of your position? <input type="checkbox"/> Yes <input type="checkbox"/> No								

Medication Treatment Information	Non-prescription medications are stocked in the camp Health Center and are used on an <u>as needed basis</u> to manage illness and injury.
	<input type="checkbox"/> Camp staff has permission to administer over-the-counter medications as necessary.
	<input type="checkbox"/> Camp staff has permission to administer over-the-counter medications as necessary, except the following:
<input type="checkbox"/> Camper should not be given any over-the-counter medications.	

Healthcare Providers	Name of camper's	Phone:
	Primary doctor(s):	()
	Dentist:	()
	Orthodontist:	()

General Questions	Has/does the participant:	YES	NO	Has/does the participant:	YES	NO
	1. Ever been hospitalized?			11. Had fainting or dizziness?		
	2. Ever had surgery?			12. Passed out/had chest pain during exercise?		
	3. Have recurrent/chronic illnesses?			13. Had mononucleosis ("mono") during the past 12 months?		
	4. Had a recent infectious disease?			14. If female, have problems with periods/menstruation?		
	5. Had a recent injury?			15. Have problems with falling asleep/sleepwalking/nightmares?		
	6. Had asthma/wheezing/shortness of breath?			16. Ever had back/joint problems?		
	7. Have diabetes?			17. Have a history of bedwetting?		
	8. Had seizures?			18. Have problems with diarrhea/constipation?		
	9. Had headaches?			19. Have any skin problems?		
	10. Wear glasses, contacts, or protective eyewear?			20. Traveled outside the country in the past 9 months?		
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	Has the camper:	Yes	No
	Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?		
	Ever been treated for emotional or behavioral difficulties or an eating disorder?		
	During the past 12 months, seen a professional to address mental/emotional health concerns?		
	Had a significant life event that continues to affect the camper's life? <i>(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)</i>		
	Please explain "Yes" answers in the space below, attaching a separate sheet if more space is needed. The camp may contact you for additional information.		

Immunization, Disease and Exam History	Has the camper had or been vaccinated for:	Yes	No	Has the camper had or been vaccinated for:	Yes	No
	Measles			Diphtheria		
	Mumps			Tetanus		
	Rubella (German Measles)			Pertussis (Whooping Cough)		
	Varicella (Chicken Pox)			Polio		
	Hepatitis B			Hib (Haemophilus Influenzae b)		
				Positive TB Mantoux Test <i>(date _____)</i>		
	Are the camper's immunizations/vaccinations up to date?					
	Date of last Tetanus shot:					
	Date of last Health Exam:					

Restriction Information	<input type="checkbox"/> I have reviewed the program/activities of the camp and feel that the camper can participate without restrictions
	<input type="checkbox"/> I have reviewed the program/activities of the camp and feel that the camper can participate with the following restrictions (<i>please describe</i>):

Additional Information	<p>YOU WILL BE CONTACTED IF:</p> <ul style="list-style-type: none"> Your camper is exposed to a communicable disease Outside medical attention is necessary (e.g., if we transport your camper to a hospital/Dr. office) Your camper is having discipline problems that jeopardize the safety of others
	<p>WHAT HAVE WE FORGOTTEN TO ASK? <i>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.</i></p>

Authorization Information	<p>PARENT/GUARDIAN AUTHORIZATION FOR HEALTH CARE</p> <p>This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.</p> <p>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.</p>	
	Signature of Custodial Parent/Guardian:	Date:
	My Camper will be riding home with :	Phone:

Staff Use Only		Yes	No		Yes	No	
		Recent exposure to communicable disease, illness, injury?			Any allergies?		
	Authorization section signed?			Meds checked in , pill counts documented?			
	Anything that requires follow-up?			All info current and complete?			
	Copy of insurance card attached?						
	Staff Initials:				Date:		