Health History Form for Camp & Retreat Ministries Staff

Camp & Retreat Ministries
Oregon-Idaho Conference

Dates of Camp Attendance _____
Name of Camp or Event _____

Site: *(Circle one)* **Latgawa** **Magruder** **Suttle Lake** **Sawtooth** **Wallowa Lake** **Other**

This form should be sent in to the camp at least 10 days prior to your arrival so that the camp staff can be aware of your needs. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp.

Mail this form to the camp
at least 10 days before the first day of the event.

PERSONAL INFORMATION:

Name_____

Home address_____ Birthdate _____

City_____ State ____ Zip _____ Gender: ☐ **Male** ☐ **Female**

Phone1_____ Phone2_____ Email: _____

EMERGENCY CONTACT: Whom should we notify in case of a medical emergency?

Name_____ Relationship_____

Address_____ Phone _____

City_____ State _____ Zip_____

DIETARY RESTRICTIONS: *Check all that apply .*

☐ No Dietary Restrictions ☐ Vegetarian ☐ Lactose Intolerant
☐ Diabetic ☐ Gluten-Free ☐ Vegan

Please give us specifics _____

HEALTH HISTORY: *Check all that apply*

☐ Epilepsy or seizures ☐ Diabetes Type 1 ☐ Heart disease ☐ Use of C-Pap Machine
☐ Knee or Hip issues ☐ Diabetes Type 2 ☐ Asthma/ respiratory ☐ Back pain or strain

Other Concerns_____

Do you have any known allergies? *(Specify):* _____

If any allergies, do you use/carry an epi-pen? _____Yes _____ No

Date of Last Tetanus shot *(if known)*_____

Are you presently taking any medications? ____Yes _____ No

If any of your required medication could cause impairment to your duties as a staff member, you should discuss this with Camp Program Director, Camp Health Care Provider, or Camp Director

Attach a list of all medications you are bringing with you to this event. Please list ALL medications being taken (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication 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.

PHYSICIAN:

Name of family physician_____ Phone _____

Address_____

PERMISSION TO PROVIDE NECESSARY TREATMENT OR EMERGENCY CARE:

In signing this form I hereby certify that this information is correct. In case of medical emergency I understand that every effort will be made to contact the emergency contact listed above. In the event they cannot be reached I hereby give permission to the medical personnel selected by the camp director to secure and administer treatment including hospitalization and to provide or arrange necessary related transportation for me. I agree to the release of any records necessary for insurance purposes.

Signature of staff person_____ **Date**_____

Print, sign and mail this form to the camp *at least 10 days before arrival at camp.*

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