

Health History Form
Children/Youth Campers
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 completed form (2 pages) should be sent in to the camp at least 10 days prior to your arrival. Attach additional pages if needed. Any changes to this form should be provided to camp health personnel **in writing** upon participant's arrival in camp.

Mail this form to the Camp Site (circled above)
at least 10 days before the first day of the event.

Camper's Name _____ Birthdate _____

Address _____ Gender: Male Female

City _____ State _____ Zip _____ email _____

Parent/Guardian Name(s): _____

Primary Phone _____ Other Phone _____ email _____

Address (if different) _____ City _____ State _____ Zip _____

If parent not available in emergency, notify: _____

Address _____ Phone _____

City _____ State _____ Zip _____ Relationship to Camper _____

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

Asthma Diabetes Type 1 Attention Deficit Disorder Frequent headaches
 Epilepsy or seizures Diabetes Type 2 Autism Spectrum Bed-wetting
 Frequent sore throats Frequent ear infections Menstrual problems

Does the camper have a health condition or special circumstance which may affect program participation housing assignment?

If yes, please explain: _____

Is camper presently taking any medications? Yes No (List all med's on second page)

Does camper have any known allergies? (Specify): _____

If any allergies, does camper use/carry an epi-pen? Yes No

Is camper current on all immunizations needed for school? Yes No

Date of Last Tetanus shot (if known) _____

INSURANCE INFORMATION:

Name of Insured: _____

Carrier: _____ Group # _____ Policy # _____

Name of family physician _____ Phone _____

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 medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for 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.

I give permission for my child's photo, oral interview or written material to be used in advertising of the camp or camping program.

Signature of parent/guardian _____ Date _____

Permission to Administer Medications

Camp & Retreat Ministries

Camp Latgawa, Camp Magruder, Sawtooth Camp, Suttle Lake Camp & Wallowa Lake Camp

I, the parent or guardian of _____ give my permission to the camp Health Care Provider or his/her designate to give the following medications (or their generic equivalents) to my child, in accordance with recommended package dosing for the specific indications below. These medications are available at camps and need not be brought by participants.

Tylenol: *Mild fever or discomforts* Yes No

Ibuprofen: *Mild fever or discomforts* Yes No

Throat Lozenges: *Cough/sore throat* Yes No

Topical Creams: *Itching, sunburn, or insect bites* Yes No

Benadryl: *Allergy symptoms* Yes No

Antacid: *Upset stomach* Yes No

Anti-diarrheal: *For diarrhea* Yes No

Permission to follow recommendations by Oregon Poison Control or Idaho Poison Control. Yes No

Signature of parent/guardian: _____ **Date** _____

Please list ALL medications (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.

Med #1 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Med #3 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Attach additional page for more medications.

All medications brought to camp must be in the original containers.

NOTE: The camp personnel will notify you if 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, discolorization and/or swelling.
- Any condition that cannot be sufficiently treated by camp personnel.
- Any condition requiring transport to other medical services.

Upon camper check-in:

Health History Form Verified _____ by _____
Date Initials

Health History Form Updated _____ by _____
Date Initials