HEALTH HISTORY FORM 2017 (PAGE 1)

(To be filled out by Parents/Guardians) State law requires an immunization record giving dates indicating that the camper is fully protected from the included diseases. A doctor or nurse must review this history form within 90 days of the start of the camp session.

Camper First Name _____

Last Name _____

Date of Birth _____ Age _____ ☐ Male ☐ Female

Home Phone (_____) _____

Address _____

City _____ State _____ Zip _____

Custodial Parents/Guardian Name _____

Father's Day Phone (_____) _____

Mother's Day Phone (_____) _____

Father's Cell Phone (_____) _____

Mother's Cell Phone (_____) _____

Emergency Contact _____

Emergency Contact's Phone (_____) _____

Health Insurance Co. _____

Policy Number _____

Policy Holder's Full Name _____

Policy Holder's Birthdate _____

Policy Holder's Employer _____

Phone (_____) _____

Insurance Co. Billing Address _____

City _____ State _____ Zip _____

Name of Camper's Physician _____

Phone (_____) _____

Name of Camper's Dentist _____

Phone (_____) _____

Name of Camper's Orthodontist _____

Phone (_____) _____

Has camper had instances with the following?

If so, give date(s).

☐ ADD/ADHD _____ ☐ Asthma _____

☐ Convulsions/Seizures _____ ☐ Behavioral Issues _____

☐ Mental Health _____ ☐ Diabetes _____

☐ Bedwetting _____ ☐ Developmental Delays ____

☐ Migraines _____ ☐ Chronic Illness _____

☐ Sleepwalking _____ ☐ Other Concerns _____

☐ Concussion _____

This camper is allergic to: ☐ Food ☐ Medicine ☐ The Environment (i.e. insect sting, seasonal allergies) Please Comment:

Severity: ☐ Life Threatening ☐ Needs medication ☐ Minor irritant

_____

_____

_____

Has camper been exposed to any significant communicable disease, including tuberculosis?

Disease _____

Date _____

(FLIP TO OPPOSITE SIDE)

HEALTH HISTORY FORM 2017 (PAGE 2)

Camper Name _____

Has camper been immunized against the following?

If so, GIVE MOST RECENT DATES (As required by law).

☐ Polio _____ ☐ Diphtheria, Pertussis, Tetanus _____

☐ MMR _____ ☐ Hepatitis B _____

☐ Chicken Pox _____

Covenant Pines Bible Camp carries over-the-counter medications in the Health Center. You do not need to send these with your child, unless they are needed on a regular basis. **It is required to send all prescription medications and over-the-counter medications in their ORIGINAL pharmacy container (with name, dose, and frequency clearly written) in order to have our nurse safely administer them.** Campers who have diabetes, asthma, and allergies must bring the appropriate emergency medications (i.e. insulin, glucagon, albuterol inhaler, epi-pens, nebulizer and medication). Campers needing medications for the above conditions will not be admitted to the session until Covenant Pines Bible Camp has received all appropriate medications in their original pharmacy container.

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.

Acetaminophen	Ibuprofen
Sudafed PE	Robitussin DM
Benadryl	Generic cough drops
Solarcaine	Antibiotic cream/Bacitracin
Calamine Lotion	Tums
Hydrocortisone cream/spray	Sting Swabs

Medication

☐ This camper will not take any daily medications while attending camp.

☐ This camper will take the following daily medication(s) or "as needed" medications while at camp:

Medication 1 _____ Reason for taking _____
When to be taken _____ Amount/dose given _____
How given _____

Medication 2 _____ Reason for taking _____
When to be taken _____ Amount/dose given _____
How given _____

Medication 3 _____ Reason for taking _____
When to be taken _____ Amount/dose given _____
How given _____

IN CASE OF EMERGENCY, IF I CANNOT BE CONTACTED, I HEREBY GIVE PERMISSION TO THE MEDICAL PERSONNEL SELECTED BY THE CAMP DIRECTOR TO SECURE AND ADMINISTER TREATMENT, INCLUDING HOSPITALIZATION, FOR THE PERSON NAMED ABOVE. THE COMPLETED FORMS MAY BE PHOTOCOPIED FOR TRIPS OUT OF CAMP.

_____

(PARENT SIGNATURE) (DATE)

☐ I have reviewed and there is no evidence of a health problem or activity limitation.

☐ Review indicates physical is necessary and must be done within 90 days of camp attendance.

Signature of reviewing Doctor or Nurse _____

Additional Comments of Physician _____

_____