



**Christian Camps  
and Conferences**

Legal Name: \_\_\_\_\_  
First Middle Last "Nickname"

Male  Female Birth Date \_\_\_\_\_ Age on arrival at camp: \_\_\_\_\_  
Month/Day/Year

## Health History Form - Parent Portion

**Directions:**

1. Parents: Please fill out pages 1 and 2 of this form as much as possible. It can also be submitted on-line at the camp website for your convenience.
2. Provide the Medical Staff portion of the form to your child's health care provider for completion. They can complete the form, or they can simply attach the information in a format specific to their practice.
3. **Return all information it to the camp by May 1st if possible.**

Home Address: \_\_\_\_\_  
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: \_\_\_\_\_ Relationship \_\_\_\_\_  
to Camper: \_\_\_\_\_ Preferred Phone: (\_\_\_\_\_) \_\_\_\_\_  
Email: \_\_\_\_\_

Home Address: \_\_\_\_\_  
(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name: \_\_\_\_\_ Relationship \_\_\_\_\_  
to Camper: \_\_\_\_\_ Preferred Phone: (\_\_\_\_\_) \_\_\_\_\_  
Email: \_\_\_\_\_

Additional contact in event parent(s)/guardian(s) can not be reached:  
Relationship \_\_\_\_\_

**Medical Insurance Information:**

This camper is covered by family medical/hospital insurance  Yes  No

**Parent/Guardian Authorization for Health Care:**

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.

Signature of Custodial Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_ Relationship \_\_\_\_\_  
to Camper: \_\_\_\_\_

*If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.*

# Health History

Page 2 of 2

Name: \_\_\_\_\_  
First Middle Last

**General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.**

Has/does the camper:

- |   |  |
|---|--|
| 1. Ever been hospitalized? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                   | 11. Had fainting or dizziness? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                        |
| 2. Ever had surgery? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                         | 12. Passed out/had chest pain during exercise?..... <input type="checkbox"/> Yes <input type="checkbox"/> No         |
| 3. Have recurrent/chronic illnesses? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No         | 13. Had mononucleosis during the past 12 months?..... <input type="checkbox"/> Yes <input type="checkbox"/> No       |
| 4. Had a recent infectious disease? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No          | 14. If female, have problems with menstruation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No        |
| 5. Had a recent injury? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                      | 15. Have problems with falling asleep/sleepwalking? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 6. Had asthma/wheezing/shortness of breath?..... <input type="checkbox"/> Yes <input type="checkbox"/> No   | 16. Ever had back/joint problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                      |
| 7. Have diabetes? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                            | 17. Have a history of bedwetting?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                      |
| 8. Had seizures? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                             | 18. Have problems with diarrhea/constipation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No          |
| 9. Had headaches? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                            | 19. Have any skin problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                            |
| 10. Wear glasses, contacts, or protective eyewear? <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Traveled outside the country in the past 9 months?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please explain "Yes" answers in the space below, noting the number of the question. For travel outside the country, please name countries visited and dates of travel.

**Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.**

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? .....  Yes  No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?.....  Yes  No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?.....  Yes  No
4. Had a significant life event that continues to affect the camper's life?.....  Yes  No  
(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

**Does your camper take script or OTC medications? If so a MD/NP/PA must write an order on page 4 of this form or provide other written authorization.**

If your camper has NOT been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

**Health-Care Providers:**

Name of camper's primary doctor(s): \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
Name of dentist(s): \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
Name of orthodontist(s): \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

**What Have We Forgotten to Ask? 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.**



**Parents/Guardians: STOP here. The rest of the form is to be completed by the camper's licensed health-care provider.**

Name: \_\_\_\_\_  
First Middle Last

**Medical Personnel:** This form is to provide the information appropriate for the health and safety of a summer camper or staff member. Please fill out this form and return to the parent, or you could simply attach a "standard" form that might be a normal part of the practice.

Weight: \_\_\_\_\_ lbs Height: \_\_\_\_\_ ft \_\_\_\_\_ in Blood Pressure \_\_\_\_\_ / \_\_\_\_\_

**Physical exam done today:**  Yes  No (If "No," date of last physical: \_\_\_\_\_)

Do you feel that the camper will require limitations or restrictions to activity while at camp?  No  Yes

If you answered "Yes" to the question above, what do you recommend? (describe below—attach additional information if needed)

**"I have reviewed the CAMPER HEALTH HISTORY FORM, and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above on this form.)"**

Name of licensed provider (please print): \_\_\_\_\_ Signature: \_\_\_\_\_ Title: \_\_\_\_\_

Office Address \_\_\_\_\_  
Street City State Zip Code

The following non-prescription medications are commonly stocked in camp Health Centers and are used on an as needed basis to manage illness and injury.

**Cross out those items the camper should not be given.**

**Acetaminophen** (Tylenol) **Aloe** **Ammonia inhalent** (for fainting) **Bacitracin ointment**  
**Bactroban 2% ointment** (Mupirocin – for skin infection)  
**Benzocaine gel** (Orasol, Anbesol – for toothaches)  
**Calamine lotion** **Calcium Carbonate** (Tums – antacid) **Cetirizine** (Zyrtec – antihistamine)  
**Dextromethorphan** (Robutussin DM, Delsym – cough syrup)  
**Diphenhydramine** (Benadryl – antihistamine) **Epinephrine** (Epipen – for anaphylaxis)  
**Generic cough drops** **Guaifenesin** (Robutussin – cough syrup) **Hydrocortisone 1% cream**  
**Ibuprofen** (Advil, Motrin) **Lidocaine Gel** (pain relieving burn gel)  
**Loperamide** (Immodium AD – antidiarrheal)  
**Loratadine** (Claritin – antihistamine) **Milk of Magnesia** (laxative)  
**Phenol spray** (Chloraseptic – Sore throat spray)  
**Phenylephrine** (Sudafed PE – decongestant) **Pseudophedrine** (Sudafed – decongestant)  
**Tolnaftate** 1% cream (antifungal)

**Allergies:**

- No Known Allergies
- To foods (list):
- To medications: (list):
- To the environment (insect stings, hay fever, etc.– list):
- Other allergies: (list):

**Describe previous reactions:**

**Diet, Nutrition:**  Eats a regular diet.  Has a medically prescribed meal plan or dietary restrictions: (describe below)

**The camper is undergoing treatment at this time for the following conditions:** (describe below)

