Health History Form for Covenant Point Bible Camp

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The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care.

Camp Code: _____ Date of Camp Attendance: _____

Please bring this form with you to camp!

❖ Camper and Contact Information:

Name:_____ Birth date:____/____/_____ Age at camp:_____
Last First Middle

Home Address:_____ Gender: ( ) Male ( ) Female
Street Address City State Zip

Custodial parent/guardian:_____ Phone: _____ Work Phone:_____

Home Address:_____
(If different from above) Street Address City State Zip

Second parent/guardian:_____ Phone: _____ Work Phone:_____

Address: _____
Street Address City State Zip

If not available in an emergency, notify: Name:_____

Relationship:_____ Phone:_____ Work Phone:_____

Address:_____
Street Address City State Zip

❖ Insurance Information:

Is the participant covered by family medical/hospital insurance? ( ) Yes ( ) No
If so, indicate carrier or plan name:_____ Group #: _____
Carrier Address:_____ Phone: _____
Street Address City State Zip

Name of family physician: _____ Phone:_____
Address:_____
Street Address City State Zip

Name of family dentist/orthodontist: _____Phone:_____
Address:_____
Street Address City State Zip

Photocopy of front and back of health insurance card must be attached to this form.

❖ Consent: These boxes must be complete for attendance.*

Parent/Guardian Authorizations: This health history is correct and complete as far as I know. My signature below indicates the previously named camper has permission to engage in all camp activities, on and off camp grounds, to be transported, and to participate in outings and field trips off Covenant Point grounds. I understand that during this travel off of camp grounds my child, named above, will be under the supervision of the group leaders from Covenant Point Bible Camp. I hereby give permission to the camp to provide routine, non-surgical medical care, dispense prescribed medications, and seek emergency medical or surgical 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 me/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. I also give permission for my child's photograph to be used in future promotional materials. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian or adult camper/staffer: _____
Printed Name: _____ Date: _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities.
Signature of minor or adult camper/staffer: _____ Date: _____

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

The following information must be filled in by the parent/ guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

❖ **Allergies:** List all known. Include medication allergies, food allergies, and other allergies.

Allergy	Describe reaction and management of the reaction.

❖ **Medications being taken.** Please list all medications, including over-the-counter and 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 it is a prescription drug), the name of the medication, the dosage, and the frequency of administration.

Medication	Dose	When administered	Reason for taking

❖ **Restrictions:**

The following restrictions, whether dietary or activity restrictions apply to this individual:

_____

_____

_____

❖ **Immunizations:**

Are all immunizations, including Tetanus/Diphtheria (DPT/TD), Polio (OPV/PV), Measles/Mumps/Rubella (MMR), Hepatitis B (HBV)*, current? ( ) Yes ( ) No *Hepatitis B (HBV) is not required.

If no, please explain: _____

_____

Date of last TB Mantoux Test: _____ Result: ( ) Positive ( ) Negative

❖ **General Questions:** Does the participant: *circle yes or no*

1.	Have any recent/current injury, illness, or infectious disease?	Yes	No
2.	Have a chronic or recurring illness/condition?	Yes	No
3.	Have frequent headaches?	Yes	No
4.	Have an orthodontic appliance being brought to camp?	Yes	No
5.	Have problems with sleepwalking?	Yes	No
6.	Have any recent/current problems with joints? (knees, ankles, etc…)	Yes	No

If yes, please explain, noting number: _____

_____

_____

_____

❖ **Additional information:** Please provide any additional information about the participant's behavior, emotional, or mental health about which the camp should be aware.

_____

_____

_____

_____

_____

All information provided on this form, to the best of my knowledge, is correct.

Signature: _____ Date: _____