Camper Health History & Authorization Form

Camp Minnesota

A Ministry of the MN Annual Conference of the United Methodist Church

Camp # _____

Please bring this completed form to camper check-in

This form is **MANDATORY** and must be completed by the legal guardian of any participant, as well as all adult participants, attending camping events. This form is **REQUIRED** at the time of camper check-in and the "Authorization Information" section (back page) MUST be signed.

Koronis Ministries • Northern Pines • KoWaKan Adventures • Servant Hearts

General Information	**Participant:**	Name (last, first, middle):	
		Birth Date:	Grade Completed:
		Gender: ☐ Male ☐ Female	
		Home Address:	
	Parent/Guardian with legal custody to be contacted in case of illness or injury:	Name:	Relationship to camper:
		Home Address (if different from above):	
		Preferred Phones: ( )	( )
		Email address:	
	Second parent/guardian or other emergency contact:	Name:	Relationship to camper:
		Preferred Phones: ( )	( )
		Email address:	
	Additional contact in event parent(s)/guardian(s) cannot be reached:	Name:	Relationship to camper:
		Preferred Phones: ( )	( )
		Email address:	

Insurance Information	**Please attach a copy of the front and back of health insurance card**
	Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No
	If so, indicate carrier or plan name:
	Policy or Group #:
	Policy holder name:

Allergy Information	☐ **No known allergies**	
	The camper is allergic to:	Please describe what the camper is allergic to, the reaction seen, and how it is treated:
	☐ Food(s)	
	☐ Medicine(s)	
	☐ The environment (insects, hay fever, etc.)	
	☐ Other	

Diet/Nutrition Information	☐ This camper eats a regular diet
	☐ This camper eats a regular vegetarian diet
	☐ This camper has special food needs (please describe below)

Medication Information

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. All medications are collected, stored, and distributed by camp health care personnel. Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely.
Bring only enough medications 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.

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

☐ This camper will take the following daily medication(s) while at camp:

Name of Medication:	Reason for taking:	Times Given:	Amount/Dose Given:	How dose is given:	Pill Count:		Initials: *(guardian and staff)*
		☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other:			In:		
Original Start Date: (mm/yyyy):					Out:		
		☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other:			In:		
Original Start Date: (mm/yyyy):					Out:		
		☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other:			In:		
Original Start Date: (mm/yyyy):					Out:		
		☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other:			In:		
Original Start Date: (mm/yyyy):					Out:		
		☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other:			In:		
Original Start Date: (mm/yyyy):					Out:		

Staff / Volunteers Only – Do you require any medication that might impair your ability to perform the essential functions of your position? ☐ **Yes** ☐ **No**

Medication Treatment Information

Non-prescription medications are stocked in the camp Health Center and are used on an as needed basis to manage illness and injury.

☐ Camp staff has permission to administer **over-the-counter** medications as necessary.

☐ Camp staff has permission to administer **over-the-counter** medications as necessary, except the following:

☐ Camper should not be given any **over-the-counter** medications.

Healthcare Providers

Name of camper's	Phone:
Primary doctor(s):	( )
Dentist:	( )
Orthodontist:	( )

General Questions

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

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

Mental, Emotional And Social Health

Has the camper:	Yes	No
Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?		
Ever been treated for emotional or behavioral difficulties or an eating disorder?		
During the past 12 months, seen a professional to address mental/emotional health concerns?		
Had a significant life event that continues to affect the camper's life? *(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, attaching a separate sheet if more space is needed. The camp may contact you for additional information.

Immunization, Disease and Exam History

Has the camper had or been vaccinated for:	Yes	No	Has the camper had or been vaccinated for:	Yes	No
Measles			Diphtheria		
Mumps			Tetanus		
Rubella (German Measles)			Pertussis (Whooping Cough)		
Varicella (Chicken Pox)			Polio		
Hepatitis B			Hib (Haemophilus Influenzae b)		
			Positive TB Mantoux Test *(date_____)*		
Are the camper's immunizations/vaccinations up to date?					
Date of last Tetanus shot:					
Date of last Health Exam:					

Restriction Information	
	☐ I have reviewed the program/activities of the camp and feel that the camper can participate without restrictions
	☐ I have reviewed the program/activities of the camp and feel that the camper can participate with the following restrictions *(please describe below):*

Additional Information	
	YOU WILL BE CONTACTED IF: • Your camper is exposed to a communicable disease • Outside medical attention is necessary (e.g., if we transport your camper to a hospital/Dr. office) • Your camper is having discipline problems that jeopardize the safety of others
	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.*

Authorization Information		
	The undersigned person represents that he/she is the custodial parent/legal guardian of the above identified participant. The Camper has my/our permission to attend the camping session from _____ to _____ (dates) at _____ (Site Name). This permission is given by me/us with full knowledge of the conditions and activities contemplated during each session (see conference camping catalog and/or site brochure for details). The participant has no physical or mental disabilities that would impair their participation except as noted above. I/We acknowledge, agree to, reconfirm and incorporate herein by reference the Release of Liability signed by me/us which is attached hereto. I also understand that the information provided on this form will be kept confidential and shared only as necessary to provide care for the participant. I understand that camp insurance is a supplemental policy only. It will pay whatever my own insurance doesn't cover (deductible or over) up to the limit of the policy. If medical (sickness, injury) care is needed, billings will be sent to the parent/guardian who will be responsible for direct payments to physician, hospital, clinic, etc. The participant is currently taking only medications listed above. The camper has no allergies known to me/us except as noted on this form. The health information/history is correct as far as I/we know. In the event of illness or injury, I/we authorize the camp, physician and/or hospital to undertake such treatment of and perform such services (including surgical) for the participant as are reasonably indicated by the circumstances.	
	Signature of Custodial Parent/Guardian:	**Date:**
	My Camper will be riding home with :	Phone:

Staff Use Only		Yes	No		Yes	No
	Recent exposure to communicable disease, illness, injury?			Any allergies?		
	Authorization section signed?			Meds checked in , pill counts documented?		
	Anything that requires follow-up?			All info current and complete?		
	Copy of insurance card attached?					
	Staff Initials:			Date:		