



2019 Camper Health History Form

ONE form per person. If registering multiple campers, make as many copies as needed.

Camper Name	Last	First	Birthdate	Primary Phone Number	Session Name
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Primary Emergency Contact		Second Emergency Contact	
Name		Name	
Address		Address	
Preferred Phone(s)		Preferred Phone(s)	
Home:		Home:	
Cell:		Cell:	
Work:		Work:	
Relationship to Camper		Relationship to Camper	

RESTRICTIONS I have reviewed the program description and activities of the camp and feel the camper can participate without restrictions
 I have reviewed the program description and activities of the camp and feel the camper can participate with restrictions or adaptations.
(Please describe on reverse side. Feel free to attach additional information if needed)

ALLERGIES No Known Allergies Food Medicine Environment (insect stings, hay fever, etc) Other
Please describe on reverse side what the camper is allergic to and the reaction seen.

DIET, NUTRITION This camper eats a regular diet This camper eats a regular vegetarian diet
 This camper has special food needs *(Please describe on reverse side & give Camp two weeks notice)*

This camper is covered by family medical/hospital insurance Yes No Policy Number _____
(Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.)

Insurance Company	Phone	Subscriber
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Camper's Primary Care Doctor	Phone	Camper's Dentist	Phone	Other Healthcare Provider (if applicable)	Phone
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HEALTH HISTORY Please circle statements that apply. Explain circled items in the space on reverse side, noting the number of the questions. The camp may contact you for additional information if necessary. **Has/does the camper:**

1) Been hospitalized	10) Wear glasses, contacts, or protective eyewear	20) Traveled outside the country in the past 9 months (please name countries visited and dates of travel)
2) Had surgery	11) Fainting or dizziness	21) Been treated for ADD or ADHD
3) Recurrent/chronic illnesses	12) Passed out/had chest pains during exercise	22) Been treated for emotional or behavioral difficulties or an eating disorder
4) Recent infectious disease	13) Mononucleosis during the past 12 months	23) During the past 12 months, seen a professional to address mental/emotional health concerns?
5) Recent injury	14) If female, have problems with periods/menstruation	24) 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)
6) Asthma/wheezing/shortness of breath	15) Problems with falling asleep/sleepwalking	25) Other:
7) Diabetes	16) Back/joint problems	
8) Seizures	17) History of bedwetting	
9) Headaches	18) Problems with diarrhea/constipation	
	19) Skin problems	

IMMUNIZATION HISTORY Please check current immunizations. *Italicized immunizations must be current:*

<input type="checkbox"/> <i>Diphtheria, tetanus, pertussis (DTaP) or Tdap</i>	<input type="checkbox"/> <i>Mumps, measles, rubella (MMR)</i>	<input type="checkbox"/> <i>Polio (IPV)</i>	<input type="checkbox"/> Haemophilus influenzae type B (HIB)
<input type="checkbox"/> Pneumococcal (PCV)	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Varicella (OR date of chicken pox _____)
			<input type="checkbox"/> Meningococcal meningitis (MCV4)

If your camper has not completed these immunization requirements, 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 _____

Camper Name	Last	First	Birthdate	Primary Phone Number	Session Name
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MEDICATION "Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. All medications (including over-the-counter medications) need to be in the original containers and must be turned in upon arrival at camp (with the exception of inhalers) and accompanied by written instructions for the medical staff person. Please discuss needed medications or special health concerns with the medical staff person at check-in.

This camper will not take any daily medications while attending camp This camper will take medication(s) while at camp. (Please List)

Name of Medication	Date Started	Reason For Taking It	When It Is Given	Amount or Dosage Given	How It Is Given

I give permission for over-the-counter medications to be administered to my child if the health care staff deems necessary.

I understand that medications will be administered per instructions in the camp's healthcare handbook, which is approved by a physician, that dosages will be administered according to the directions on the bottle unless a physician directs otherwise, and that the health history form will be reviewed for allergies and parental recommendations prior to administration of over-the-counter medications. (Please list below any over-the-counter medications that you **DO NOT** want administered to your child.)



Signature of Custodial Parent/Guardian _____ Date _____ Relationship to Camper _____

We need to know who will be picking up your camper on the last day of camp. If this information changes prior to or during your child's stay at camp, please call us to provide updated information. **Name of Person Picking Up Camper at Check-Out:**

What Have We Forgotten to Ask? To help make your child's visit to camp successful, it is vital that we are aware of any unique needs or special concerns they may have. Please provide description of restrictions, allergies, diet, nutrition, information about the camper's health, special learning considerations, family circumstances, relevant experiences, or anything that will help us better prepare for your child's upcoming camp visit. **Please attach additional information if needed.**

IMPORTANT—THIS BOX MUST BE READ AND SIGNED FOR ATTENDANCE

Each United Methodist Camp and Retreat Center ("Camp") in the Great Plains Annual Conference of the United Methodist Church ("Conference") offers a variety of services and voluntary activities designed to enrich the camping or retreat experience. These services and voluntary activities may include, without limitation, the provision of food, lodging, transportation, as well as the sponsorship of challenging and educational activities often associated with camping and the outdoors, such as hiking, boating, swimming, campfires, fishing, low and high rope courses, horseback riding, archery, tree climbing, ziplines, and other opportunities. Both participants and staff members (including volunteers) may have the opportunity to participate in one or all of these activities. Additional releases for special activities may be required. I understand that reasonable measures will be taken to safeguard the health and safety of all participants. I understand that some camp activities have inherent risks of serious injury or death. The person described has permission to participate in all camp activities except as noted on this form and accompanying information. I understand that participation in camp activities and receipt of camp services is voluntary, that I/my child may decline to participate in any activity, and that I/my child has the obligation to notify a camp official of anything I/they feel to be unsafe and, if necessary, to immediately leave the area or stop participating in the event which I/they feel may be unsafe. I will assure that I/my child is properly prepared and able to participate, willing to abide by camp policies, and follow directions of camp personnel. I understand that I/my child may be transported in a licensed, insured Conference vehicle or a licensed, insured private vehicle.

This health history is correct and accurately reflects the health status of the camper to whom it pertains. I understand I will be notified as soon as possible in case of any emergency or illness affecting my child. I understand that I/my child may be transported in a licensed, insured Conference vehicle or a licensed, insured private vehicle. 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 authorize listed emergency contacts and/or camp staff to act on my behalf. Furthermore, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I accept responsibility for the costs of such treatment. 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.

I understand that my child can be dismissed from camp for reasons including, but not limited to: contagious illness, chronically disruptive behaviors, illegal activity, breaking of camp rules, or destruction of property. If my child is dismissed from camp, I understand it is my responsibility to arrange and pay for transportation for my child to return home, and that no refunds will be issued for campers going home early for disciplinary action or because they are missing home.

Unless I have checked the box below, I give Great Plains UM Camps permission to take and use photographs or other media representations of myself or my child in promotional material, including websites, brochures, videos, and other means. I understand that my child will not be named in this material.

I DO NOT want Great Plains UM Camps to use any images of my child for promotional materials. (Please initial and send current photo to be used later to identify camper)



I have read and understand the authorization section and will abide by judgments made by Great Plains UM Camp staff.
Signature of Custodial Parent/Guardian _____ Date _____ Relationship to Camper _____



With my parents/guardian, I have completed the above information and will assume responsibility for taking my medication as administered by camp staff and for restricting any activities agreed upon and listed above. I will exercise good judgment in regard to my own health, safety, behavior, and well-being while at camp.

Signature of Camper _____ Date _____