Summer Camp Medical Form 2026

CAMP Fontanelle
A Great Plains UNITED METHODIST CAMP

CAMPER INFORMATION

Last Name _____ First Name _____ D.O.B. ____ /____ /____

Session Name: _____ Primary Phone: _____

EMERGENCY CONTACT INFORMATION

Primary Emergency Contact: _____

Home Phone _____

Work/Cell Phone _____

Address: _____

Relationship to Camper _____

Secondary Emergency Contact: _____

Home Phone _____

Work/Cell Phone _____

Address: _____

Relationship to Camper _____

INSURANCE INFORMATION

Is the camper covered by family medical/hospital insurance? ☐ Yes ☐ No If Yes, please provide the following:

Insurance Company _____ Phone _____

Policy Number _____

Subscriber _____

Camper's Primary Care Doctor _____ Phone _____

Camper's Dentist _____ Phone _____

Other Healthcare Provider (If applicable) _____ Phone _____

RESTRICTIONS (ACTIVITY/DIETARY)

RESTRICTIONS:

☐ I have reviewed the program descriptions 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 the following restrictions or adaptations. (Please specify below)

ALLERGIES: ☐ No Known Allergies ☐ Food ☐ Medicine ☐ Environmental ☐ Other
(If you marked anything other than "No Known Allergies" please be share below the allergen, type of reaction, and treatment.)

Special Dietary Needs: ☐ Camper eats a regular diet ☐ Camper eats a vegetarian diet ☐ Other:
If you marked "Other" please share specifics in the space below at least 2 weeks in advance of camp.

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IMMUNIZATION INFORMATION

Check the appropriate box below and provide parent/guardian signature. Relationship to Camper

☐ My child is up-to-date on all required vaccinations. _____ _____

☐ My child is **NOT** up-to-date on all required vaccinations. I accept the risk to my child from not being fully immunized.

Parent/Guardian Signature _____ Relationship to Camper _____

Please provide the date of the child's last tetanus booster (dT) or (Tdap): _____

Summer Camp Medical Form (cont.)

Last Name _____ First Name _____ D.O.B. ____ /____ /____

Session Name: _____ Primary Phone: _____

CAMPER HEALTH HISTORY

Please check all that apply. For any checked boxes please share specifics in the space provided, noting the number of the checked box in the explanation.

Has/does the camper:

- ☐ 1. Had Surgery
- ☐ 2. Recurrent/chronic illnesses
- ☐ 3. Recent infectious disease
- ☐ 4. Recent Injury
- ☐ 5. Asthma/wheezing/shortness of breath
- ☐ 6. Diabetes Seizures
- ☐ 7. Headaches
- ☐ 8. Wear glasses, contacts, eye-wear
- ☐ 9. Fainting or Dizziness
- ☐ 10.Passed Out/chest pains during exercise
- ☐ 11.Mononucleosis in the past 12 months
- ☐ 12. Problems falling asleep/sleepwalking
- ☐ 13. Back/joint problems
- ☐ 14. History of bed wetting
- ☐ 15. Problems with diarrhea/constipation
- ☐ 16. Skin problems
- ☐ 17. Treated or Counseled for Emotional or Behavior problems
- ☐ 18. Difficulties Treated for eating disorder
- ☐ 19. Treated for ADD or ADHD
- ☐ 20. Other:

Please use this space to explain any boxes that were checked above.

Have you traveled outside the country in the past 9 months? If so, please list places below.

Please share any significant life event that continues to affect the campers life. (i,e, history of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, etc.)

MEDICATION INFORMATION AND RELEASE

Medication: Medication is any substance a person takes to maintain and/or improve health. This includes vitamins and natural remedies. All medications (including over the counter medications) need to be in the original container and MUST be turned in to the health coordinator during check-in. There are exceptions for inhalers and epi-pens. Please indicate below any medications your child will be taking at camp along with the requested information for each medication.

☐ **My child will NOT be taking any daily medications while at camp.**

Name of Medication	Date Started	Reason for taking	When is it given	Amount or Dosage Given	How is it Given

I give permission for over-the-counter medications to be administered to my child if the health coordinator deems it 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 health history forms will be reviewed for allergies and parental recommendations prior to administration of over-the-counter medications. (Please list below and over-the-counter medications you DO NOT want administered to your child.)

Signature of Parent/Guardian: _____ **Date:** _____ **Relationship to Camper** _____