

CHRISTIAN FRIENDSHIP CAMP HEALTH FORM

For adults with developmental disabilities

TO BE COMPLETED BY PARENT OR RESPONSIBLE AGENCY:

Name: _____ Birthdate: _____ Age: _____ Sex: _____

Address: _____

Name of Parent(s)/Guardian(s): _____

Phone Numbers: Home _____ Work _____

If not available in emergency, please notify: _____

Phone Numbers: Home _____ Work _____

Name of present physician: _____ Phone: _____

Name of Dentist/Orthodontist: _____ Phone: _____

Has the camper had any of the following (if yes, give approximate date):

____ Chicken Pox ____ Measles ____ German Measles
____ Mumps ____ Diabetes(or Borderline) ____ Seizures (list date of last seizure)

List any recent exposures to contagious disease: _____

Does the camper have allergic reactions to any of the following:

____ Penicillin ____ Other Drugs (specify) _____
____ Pollens ____ Foods (specify) _____
____ Bee Stings ____ Other (specify) _____

If "yes" to any of the above, please explain the severity of reaction: _____

Is the camper prone to any of the following:

____ Frequent Colds	____ Athlete's Foot	____ Seizures
____ Earaches	____ Fainting	____ Diabetes
____ Bronchitis	____ Incontinence	____ Poison Ivy
____ Heart Trouble	____ Bleeding/Clotting Disorders	____ Constipation
____ Kidney Trouble	____ Emotional Disturbances	____ Sleep Walking
____ Upset Stomach	____ Diarrhea	____ Asthma

Please describe in detail the nature of the problem(s) and the method of treatment: _____

Does the camper require any daily medication: ____ YES ____ NO

Please list all medications, include dosage and distribution times. Please attach an additional sheet if needed.

MEDICATIONS MUST BE BROUGHT IN THEIR ORIGINAL CONTAINERS WITH CAMPER'S NAME, NAME OF DRUG, DOSAGE, DOCTOR, PRESCRIPTION NUMBER, AND PHARMACY SUPPLYING DRUG. YOU MUST SEND AN ADEQUATE SUPPLY.

Are there any other health issues or behavioral issues the staff should know about? YES NO

If YES, explain: _____

Does the camper require a special diet? YES NO

If YES, explain: _____

Does the camper need attention in any of the following activities (if YES, explain):

Dressing _____
Eating _____
Toileting _____
Bathing _____
Sleeping _____
Swimming _____
Other _____

IMMUNIZATION RECORD: please list dates of most recent booster.

This is required by the State Department of Health

_____ Measles _____ Rubella _____ Mumps _____ Tetanus
_____ Pertusis _____ Diptheria _____ Polio

Has the camper had a physical by a doctor in the past two years? YES NO

If YES, give date and name of doctor: _____

If NO, please have one prior to camp and have a doctor fill out the Physician's Examination Form.

AUTHORIZATION FOR TREATMENT

IN AN EMERGENCY, I hereby give my permission to the liscensed physician selected by the camp director to administer proper treatment and routine medical care, anesthesia, surgery, and hospitalization for persons named on this form, and to release necessary medical information for insurance purposes.

I also authorize the camp nurse to treat the camper as is determined necessary while at camp (e.g. "Tylenol").

Signature of Parent or Guardian

Date

OTHER AUTHORIZATIONS

I hereby give my permission for Christian Friendship Camp to use photographs taken of this camper during his/her attendance at camp for the purpose of promoting this camp as sponsored by the United Methodist Camping Program.

Signature of Parent or Guardian

Date

INSURANCE INFORMATION

INSURANCE COVERAGE is for expenses over and above those covered by the camper's insurance policy. There should be NO out-of-pocket expenses for those incidents which are camp related. Camp insurance will cover any deductible, prescriptions, and expenses in excess of your company's maximum coverage. (Please note that our coverage does not cover illness which is not specifically camp related, e.g. appendicitis or strep throat).

Camper's Name: _____

Insurance Co.: _____ Policy #: _____