WASHINGTON NORTH IDAHO CONFERENCE
UNITED CHURCH OF CHRIST
TEEN HEALTH FORM

This form must be completed by the parent/guardian NOT MORE THE 10 DAYS before the beginning of camp that the camper is attending. The completed form must be BROUGHT WITH THE CAMPER on the opening day of camp. If the form is not brought to camp, the parent/guardian will be called collect and asked to send the form immediately. The completed form MUST be at the campsite for each camper.

CAMPER'S NAME_____AGE____BIRTHDATE_____

ADDRESS_____
Street City State Zip

PARENT'S NAME(S)_____

HOME PHONE(_____)_____WORK PHONE(_____)_____

IN EMERGENCY NOTIFY:

NAME_____PHONE#(_____)_____RELATIONSHIP_____

NAME_____PHONE#(_____)_____RELATIONSHIP_____

NAME OF INSURANCE
CARRIER_____MEMBER#_____
Please attach photocopies of the front and back of the camper's insurance card.

HEALTH HISTORY

ALLERGIES TO MEDICATIONS_____

TO FOODS_____

LIST ANY DIETARY RESTRICTIONS_____
VEGETARIAN? _____

DATE OF LAST TETANUS BOOSTER_____

DOES THE CAMPER TAKE MEDICATIONS REGULARLY? IF SO, WHAT?

_____

_____

WILL THE CAMPER TAKE MEDICATION WHILE AT CAMP?_____IF YES, PLEASE LIST:

MEDICATION AND DOSAGE SCHEDULE

_____

_____

_____

ARE THERE ANY SIDE EFFECTS OF THE MEDICATION THAT WE SHOULD BE AWARE OF? _____

_____

IS THE CAMPER SENSITIVE TO BEESTINGS? _____IF SO, HOW SHOULD THE CAMPER BE TREATED IF STUNG? _____

_____

IN CASE OF HEADACHE, UPSET STOMACH, ETC., WHAT MEDICATION DO YOU PREFER YOUR CAMPER TO RECEIVE? _____

_____

IS THERE OTHER INFORMATION REGARDING THE CAMPER WHICH YOU WANT THE DIRECTOR/COUNSELOR TO KNOW ABOUT, SUCH AS:

_____SLEEPWALKING _____DEPRESSION _____BEHAVIOR CONCERNS

_____OTHER SLEEP DIFFICULTIES _____LEARNING DIFFICULTIES _____A.D.D.

_____OTHER (PLEASE EXPLAIN_____

_____

PAST HISTORY (PLEASE CHECK IF APPLICABLE)

_____EPILEPSY ____DIABETES ____HEART TROUBLE

_____NOSE BLEEDS _____ASTHMA _____SEVERE CONSTIPATION

_____RECENT SURGERY _____OTHER (PLEASE EXPLAIN)

_____

DOES THE CAMPER HAVE ANY OTHER LIMITATIONS OR MEDICAL PROBLEMS WE SHOULD BE AWARE OF?_____

_____

WHO WILL PROVIDE TRANSPORTATION HOME FOR YOUR CAMPER? _____

_____

DURING MY CHILD'S STAY AT CAMP, THE CAMP DIRECTOR OR NURSE HAS MY PERMISSION TO AUTHORIZE MEDICAL AND/OR SURGICAL TREATMENT FOR MY CHILD IN THE EVENT THAT I CANNOT BE REACHED. ANY EXCEPTIONS TO THIS CONSENT ARE NOTED ON SEPARATE ENCLOSURE.

CAMP #, NAME, AND DATES THE CAMPER IS ATTENDING_____

_____

_____

PARENT/GUARDIAN'S SIGNATURE_____DATE_____