

KIDS' & INTERMEDIATE CAMPERS

WASHINGTON NORTH IDAHO CONFERENCE
UNITED CHURCH OF CHRIST
YOUTH 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 _____

ALLERGIES 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
_____	_____
_____	_____
_____	_____

(Over, please)

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:

_____BEDWETTING_____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 _____