Wilderness Camp at Stronghold
Sponsored by a Coalition of Presbyterian Churches of Great Rivers
Health History, Medication Authorization, & Treatment Authorization Forms
For Camp Participants: Children, Youth and Adults

Please complete this health information as completely and accurately as possible. This information will allow a health care facility to treat you or your child with minimal delays in case of an emergency.

Participant

Name ____
Last First

Address ____

City/State/Zip ________________________________

Phone ____

Date of Birth ____/____/____

Age at camp time _________

Sex ___ Male ___ Female

Social Security # ______-____-_______

Custodial Parent/Guardian

Name ____
Last First

Address ____

City/State/Zip ________________________________

Home Phone ____________________________________

Work Phone ____________________________________

Cell Phone ____________________________________

In Case of Emergency Please Notify:

Name ____
Last First

Relationship __________________________________

Home Address __________________________________

City/State/Zip ________________________________

Work Phone ____________________________________

Cell Phone ____________________________________

Insurance Information

Is the participant covered by family medical/hospitalization Insurance?

___YES ___NO

If so, Insurance carrier is:

____

Carrier Name __________________________________
Policy # ______________________________________
Type of Policy: ___Group ___Individual
Name of Policy Holder:____________________________

Please include a copy of both sides of your insurance card.

Name

____
First Last

Camp Date

____

Treatment Authorization Release

Participant/Parent/Guardian Authorization: In registering for this camp, the Participant/Parent/Guardian authorizes the camp director to secure medical treatment for this camper in case of any illness or accident for which the camp director or first aid provider feels professional medical attention is required. I here by give permission to hospitalize and secure proper treatment for my child.

Signature of Parent/Guardian/Participant (if legal age)

____
Signature

____
Print full name

_______________ ______________________________
Date Relationship

Prescription Medication*

Medication ____________________________________
Purpose ______________________________________
Dosage _______________________________________
Given when? ___________________________________
If as needed, describe indications: ________________
____
Any other information that we should know? (side effects, taken with food, etc.?) ____________________________
____

***Please include additional Medication Information on page 4. All medications must be in original container with full label showing camper's name, dose, etc.**

Over the Counter Medications

Medication ____________________________________
Purpose ______________________________________
Dosage _______________________________________
Given when? ___________________________________
If as needed, describe indications: ________________
____
Any other information that we should know? (side effects, taken with food, etc.?) ____________________________
____

May your child be give Children's Tylenol for headache or body ache at the director's discretion? ___YES ___ NO

Participant Name ______________________________
First Last

GENERAL INFORMATION

Date of last physical: ___/___/___

Has or does the participant: (circle Y-yes or N- no)

1. Had a recent injury, illness or infectious disease? Y N
2. Have a chronic or recurring illness or condition? Y N
3. Ever been hospitalized? Y N
4. Ever had surgery? Y N
5. Have frequent headaches? Y N
6. Ever been knocked unconscious? Y N
7. Ever had a head injury? Y N
8. Wear glasses, contacts or protective eye wear? Y N
9. Had frequent ear infections? Y N
10. Ever passed out/gotten dizzy during/after exercise? Y N
11. Ever had seizures? Y N
12. Ever had chest pains during or after exercise? Y N
13. Ever had high blood pressure? Y N
14. Ever been diagnosed with a heart murmur? Y N
15. Ever had back problems? Y N
16. Ever had problems with joints? Y N
17. Brought an orthodontic device to camp? Y N
18. Have any skin problems? Y N
19. Have diabetes? Y N
20. Have asthma? Y N
21. Had mononucleosis in the past 12 months Y N
22. Have problems with diarrhea or constipation? Y N
23. Sleepwalk? Y N
24. Have a history of bed-wetting? Y N
25. Ever had an eating disorder? Y N
26. Have emotional difficulties needing professional help? Y N

Noting the question number in General Information, please explain any "YES" answers on page 4.

Physician Information

Physician ______________________________

Address ______________________________

City/State/Zip ______________________________

Phone ______________________________

LIST ALL KNOWN ALLERGIES (medical, food, insects, etc.) **AND REACTIONS:**

Allergy	Reaction
____________	____________
____________	____________
____________	____________
____________	____________

FOOD RESTRICTIONS (circle those that apply)

Red meat	Pork
Dairy products	Poultry
Seafood	Eggs
Nuts	Other:

Provide any additional information or restrictions relating to the participant's behavior and physical, emotional, or mental health limitations, etc. that the camp should be aware of: (please use page 4 if needed)

____

____

____

IMMUNIZATION HISTORY – Give the dates of Immunizations (month/year) for the following vaccines:

	Month/Year	Month/Year	Month/Year	Month/Year
DPT	______	______	______	______
T/D	______	______	______	______
Polio	______	______	______	______
MMR	______	______	______	______
Or Measles	______	______	______	______
Mumps	______	______	______	______
Rubella	______	______	______	______
Haemophilus Influenze	______	______	______	______
Hepatitis B	______	______	______	______
Varicella (chicken pox)	______	______	______	______
BCG	______	______	______	______

Date of Last Tetanus: ___/__/____

Date of Last TB Mantouz Test: __/__/____ Result: __Positive __Negative

Has participant ever had: ___Measles ___Chicken Pox ___German Measles ___ Mumps ___ Hepatitus

Name ______________________________
First Last

Transportation Designation

Below is a list of people who have permission to take my participant(s) home from camp:

NAME	CONTACT INFORMATION
____	__________________________
____	__________________________
____	__________________________
____	__________________________

If plans change, I will send a signed note indicating who will be allowed to pick up my participant(s).

____ ___________________________
Parent/Guardian Signature Date

Camp Closing will begin at 5:00 p.m. on __________ with a bonfire and skits. Please plan to arrive by 5:00p.m. No participant shall leave camp without formal checkout by a parent of designated person.

I hereby release all counselors, leaders, representatives, and camp organizers, from responsibility and liability for any injury or illness that my child may sustain during the event.

I give my permission for my child _____________________________to have their photographic or video image used in promotional DVD or other promotional media for future camping programs.

Parent/Guardian Signature _________________________________ Date __________

Name ______________________________
First Last

PRESCRIPTIONS
& OVER THE COUNTER MEDICATION **Additional Information**

GENERAL INFORMATION **Additional Information**

ALLERGY AND FOOD RESTRICTION **Additional Information**