

HEALTH FORM - Complete Both Sides

Health Form due by June 7, 2009

Return this form to: Camp Registrar, St. Paul's Evangelical Church, 9801 Olive Blvd., Creve Coeur, MO 63141

Camper's Name _____ Home Phone (____) _____ Gender _____
Date of Birth _____ Age at Camp _____
Address _____ City _____ State _____ Zip _____
Camper lives with: Both Parents ___; Mother ___; Father ___; Other _____
Mother(Guardian) _____ Father (Guardian) _____
Work Phone (____) _____ Work Phone (____) _____

Emergency Contacts (To be used if we are unable to reach parents.)

Name _____ Relationship _____ Phone (____) _____
Name _____ Relationship _____ Phone(____) _____

Name of Family Physician _____ Phone (____) _____

Name of Dentist/Orthodontist _____ Phone (____) _____

Family Medical/Hospital Insurance: Carrier _____ Policy or Group # _____

Dental Insurance: Carrier _____ Policy or Group # _____

**** PLEASE INCLUDE A COPY OF INSURANCE CARDS WITH HEALTH FORM ****

Description of any Limitations or Restrictions on Camp Activities _____

IMMUNIZATION HISTORY: Record the date (month & year) of basic immunization and most recent booster doses OR

Attach a current copy of your child's school/clinic/physician immunization record.

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria } Pertusis (Whooping Cough) } or DPT* Tetanus }		
Tetanus } Diphtheria } Or TD*		
Tetanus		
Oral Polio (Sabin)* TOPV		
Measles (hard measles, red measles, rubeola)		
Mumps		
Rubella (German measles, red measles, rubeola)		
Other - specify		
Haemophilus influenza b (HIB)		
Hepatitis B		

Date of most recent Tuberculin Test _____ Results _____

IMPORTANT - This section must be completed for attendance.

THIS HEALTH FORM is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted.

PERMISSION TO PROVIDE NECESSARY TREATMENT OR EMERGENCY CARE: I hereby give permission to the medical personnel selected by the camp administration to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp administration to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

SIGNATURE _____ DATE _____
(Parent/Legal Guardian)

WITNESS _____ DATE _____

I also understand and agree to abide by the restrictions placed on my camp activities.

SIGNATURE OF CAMPER _____ DATE _____
(Camper to sign if restrictions are placed on child)

NAME OF CAMPER _____ Date of Last Physical Exam _____

HEALTH HISTORY: (Please answer Yes or No; if answer is Yes, give approximate dated.)

			<u>Allergies</u>	
<input type="checkbox"/> Frequent Ear Infections	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Asthma
<input type="checkbox"/> Heart Defect/Disease	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Measles	<input type="checkbox"/> Poison Ivy/Oak	<input type="checkbox"/> Insect Stings
<input type="checkbox"/> Epilepsy/Convulsions	<input type="checkbox"/> Diabetes	<input type="checkbox"/> German Measles	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Bee Stings
<input type="checkbox"/> Psychiatric Treatment	<input type="checkbox"/> Fainting/Dizzy Spells	<input type="checkbox"/> (Rubella)	<input type="checkbox"/> Other Drugs (Specify) _____	
<input type="checkbox"/> Bleeding/Clotting Disorders	<input type="checkbox"/> Sleep Disorders	<input type="checkbox"/> Mumps	<input type="checkbox"/> Other (specify) _____	

Other Diseases or Details of Above _____

Food Allergies/Dietary Modifications _____

Operations, Major Injuries or Hospitalization (include dates) _____

Disability or Chronic or Recurring Illness _____

Items your child may need help with while at camp: Fear of Dark ___ Sleepwalking ___ Bed wetting ___ Other _____

Any additional information about the participant's behavior, special needs, disabilities (physical, mental, learning, developmental), or physical, emotional or mental health about which the camp should be aware. Include recent trauma or life changes.

For Females: Has she menstruated? ___ If not, has she been told about it? ___ Is her menstrual history normal? _____

MEDICATION: List all medications camper has taken in the past six (6) months. Include additional page if necessary.

Name _____ Reason _____

Name _____ Reason _____

Camper's Current Weight _____

MEDICATIONS TO BE TAKEN AT CAMP:

Does the medical staff have your permission to dispense over-the-counter medications (i.e. Tylenol, Benadryl, cough drops, etc.) as deemed appropriate? ___ Exceptions? _____

PLEASE INCLUDE A TYPED OR PRINTED LIST OF ALL PRESCRIPTION MEDICATIONS AND DIRECTIONS THAT WILL ACCOMPANY CAMPER.

(NOTE: ALL MEDICATIONS MUST BE IN ORIGINAL BOTTLES WITH PHARMACY INFORMATION VISIBLE.)

*****HEALTH CARE RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL (NOT REQUIRED)*****

I have examined the above named camp applicant within the past two years. Date Examined _____
Date of Last Tetanus Booster _____

In my opinion, the above named applicant ___ is ___ is not able to participate in an active camp program.

The applicant is under care of a physician for the following condition(s) _____

Current Treatments _____

Recommendations & Restrictions While in Camp _____

Signature of Licensed Medical Personnel _____ Date _____

Printed Name of L.M.P. _____ Phone () _____