Camp Session # ______ Camp Location ___________
Camp Description ________________________
Dates of Camp Attendance _____________

2009 Health History Form
Adult Campers/ Volunteers (over age 18)
Presbytery of the Cascades Summer Camps

This form should be sent in to the camp office two weeks prior to your arrival at camp so camp staff will be aware of your needs. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp.

Please fill this out and return as soon as possible:

Presbytery of the Cascades Camp Office
5441 S.E. Belmont St.
Portland, Oregon 97215-1837

PERSONAL INFORMATION:

Name_______________________ Social Security #_______________

Home address_______________________ Gender: (circle one) **Male** **Female**

City_______________State _______Zip________ Birthdate_______________

Phone____________

Daytime Phone (if different) (   )_______________ Email Address: _______________

EMERGENCY CONTACT:

Whom should we notify in case of a medical emergency?

Name_______________________ Relationship_______________

Address_______________________ Phone (   )_______________

City_______________State_______Zip________Work/Other phone_______________

Photo Waiver (please check one)

___ I may appear in photos that are used for camp promotion and/or which may be posted online with password protection to make them available to myself and other campers of the camp I participate in and their families.

___ I may not appear in photos that are used for camp promotion or are posted online for campers and their family.

FOOD RESTRICTIONS: (circle those that apply)

I Do not eat: Red Meat Dairy Products Poultry Seafood Eggs

Other____

Dietary needs: Low Salt Low Fat Diabetic Lactose Intolerant

Other____

HEALTH CONDITIONS:

Date of Last Tetanus Shot _______________ Blood Type_______________*(if known)*

Do you have a health condition (e.g. allergies, chronic conditions) or special circumstances which may affect program participation, special housing need, or anything we ought to know prior to emergency treatment? **Yes** **No**

If yes, please explain: ____

____

MEDICATIONS BEING TAKEN:

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. **Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.**

Med#1_______________________ Dosage __________ Schedule_______________

Med#2_______________________ Dosage __________ Schedule_______________

Med#3_______________________ Dosage __________ Schedule_______________

Attach additional pages for more medications.

PHYSICIAN:

Name of physician_______________________ Phone (   )_______________

PERMISSION TO PROVIDE NECESSARY TREATMENT OR EMERGENCY CARE:

In signing this form I hereby certify that this information is correct. In case of medical emergency I understand that every effort will be made to contact the emergency contact listed above. In the event they cannot be reached I hereby give permission to the medical personnel selected by the camp director to secure and administer treatment including hospitalization and to provide or arrange necessary related transportation for me.

Signature of Adult camper/staff _______________________ **Date**_______________