

# 2009 Health History and Waiver Form

Children/Youth Campers (under age 18)

Presbytery of the Cascades Summer Camps

Camp Session # \_\_\_\_\_ Camp Location \_\_\_\_\_

Camp Description \_\_\_\_\_

Dates of Camp Attendance \_\_\_\_\_

This completed form (front & back) should be sent to the Presbytery camp office 2 weeks prior to your arrival at camp so staff will be aware of your needs. Attach additional pages if needed. Please double check that all information is correct, including camp session. Any changes in the camper's health needs should be documented *in writing* upon the participants arrival .

Mail to: Presbytery of the Cascades  
Camp Office  
5441 SE Belmont St.  
Portland OR 97218

Camper's Name \_\_\_\_\_

Address \_\_\_\_\_ Gender: \_\_\_\_\_ Birth Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Social Security # \_\_\_\_\_

Used by hospitals for identification

Parent/Guardian Name(s): \_\_\_\_\_ Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

Address (if different) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If parent not available in emergency, notify: \_\_\_\_\_

Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Other Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

Does camper have any known allergies?  Yes  No

Allergies to medications: \_\_\_\_\_

Food allergies: \_\_\_\_\_

Other Allergies : \_\_\_\_\_

List any dietary restrictions: \_\_\_\_\_

Health History: (Check any that apply)

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Epilepsy or seizures  | <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Menstrual problems         | <input type="checkbox"/> Asthma        |
| <input type="checkbox"/> Frequent sore throats | <input type="checkbox"/> Headaches               | <input type="checkbox"/> Bed-wetting                | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Back pain or strain   | <input type="checkbox"/> Alcohol/drug addiction  | <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Diabetes      |
| <input type="checkbox"/> Other: _____          |  |   |  |

Pertinent past medical treatment: \_\_\_\_\_

Is camper presently taking or using any type of medication(s) or drug(s)?  Yes  No

If yes, Specify and complete med report on reverse side: \_\_\_\_\_

Is the camper current on all immunizations needed for school?  Yes  No

Date of Last Tetanus shot: \_\_\_\_\_ Blood Type \_\_\_\_\_ (if known)

Does the camper 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: \_\_\_\_\_

Family Medical Insurance:  Yes  No Name of Insured: \_\_\_\_\_

Carrier: \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Name of family physician \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

## Photo Release

This camper may appear in photos or film used for promoting the Presbytery Camp program and campsite .

This camper may not appear in photos or film used for promoting the Presbytery Camp program and campsite.

## Parent/Guardian Authorization:

My child has permission to take part in all camp activities under supervision unless limitations are noted above, and I agree that the camp or camp personnel will not be held responsible for accidents arising there from. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for my child.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed health form may be photocopied for trips out of camp.

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

Please complete the other side of this form

*Presbytery of the Cascades Summer Camp Ministries*

I, the parent or guardian of \_\_\_\_\_ give my permission to the camp Health Care Provider or his/her designate to give the following medications (or their generic equivalents) to my child, in accordance with recommended package dosing for the specific indications below. These medications are available at camps and need not be brought by participants.

	Yes	No		Yes	No
<b>Tylenol:</b> <i>Mild fever or discomforts</i>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Benadryl:</b> <i>Allergy symptoms</i>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Ibuprofen:</b> <i>Mild fever or discomforts</i>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Antacid:</b> <i>Upset stomach</i>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Throat Lozenges:</b> <i>Cough/sore throat</i>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Anti-diarrheal:</b> <i>For diarrhea</i>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Topical Creams:</b> <i>Itching, sunburn, or insect bites</i>	<input type="checkbox"/>	<input type="checkbox"/>			
<b>Permission to follow recommendations by Oregon Poison Control or Idaho Poison Control.</b>	<input type="checkbox"/>	<input type="checkbox"/>			

**Signature of parent/guardian:** \_\_\_\_\_ **Date** \_\_\_\_\_

*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 \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

Med #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

*Attach additional page for more medications.*

**All medications brought to camp must be in the original containers.**

- NOTE: The camp personnel will notify you if your child displays the following symptoms:
- o Any illness that persists longer than 24 hours; including fevers, coughs, excess expulsion of bodily fluids, allergic reactions, severe tiredness.
  - o Any injury that causes severe prolonged pain, discolorization and/or swelling.
  - o Any condition that cannot be sufficiently treated by camp personnel.
  - o Any condition requiring transport to other medical services.

<b><u>Upon camper check-in:</u></b>	
Health History Form Verified	_____ by _____ <small>Date Initials</small>
Health History Form Updated	_____ by _____ <small>Date Initials</small>