

**2010 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.

<b>Camp Session #</b> _____ <b>Camp Location</b> _____
<b>Camp Description</b> _____
<b>Dates of Camp Attendance</b> _____

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** \_\_\_\_\_

This document was created with Win2PDF available at <http://www.win2pdf.com>.  
The unregistered version of Win2PDF is for evaluation or non-commercial use only.  
This page will not be added after purchasing Win2PDF.