Teenage Christian Camp Health Form

The health form is kept confidential and used by our health services staff (or emergency medical personnel). **Every camper needs a completed health form to participate in any summer camp programs.**

SECTION I – BASIC CONTACT INFORMATION

Camper Name____
LAST FIRST MIDDLE

Birth date_______/_______/_______ Age ___________ Gender Male Female

Home Address____
STREET CITY STATE ZIP

Parent/Guardian #1
Name____Relationship:_______________
Home Phone__________________________ Cell Phone__________________________

Parent/Guardian #2
Name____Relationship:_______________Home
Phone__________________________ Cell Phone__________________________

Additional Emergency Contact_________________________________ Relationship ______________
Home Phone__________________________ Cell Phone__________________________

Family Physician Name____ Phone_______________________

SECTION II – INSURANCE INFORMATION

Insurance Carrier____
Group #____ Policy #____________________________________
Policy Holder's Name____ Relationship to participant_____________

SECTION III – MEDICATIONS

Will camper be taking medications while at camp? **Yes No** *(Medications include prescription, over-the-counter, vitamins, inhalers, etc.)*

If camper will be taking medications while at camp, it is Tennessee state law to secure your consent for medication distribution and for the use of medical devices. Please list all (prescription and non-prescription). Include the medication name, prescribing physician, physicians' phone number, and the dosage instructions. Use an additional sheet if needed. When you check-in at camp, please provide all medications (in their original packaging that identifies the prescribing physician (if prescription drug), the name of the medication, the dosage, and frequency of administration. Medications for life-threatening conditions (i.e. bee sting kits, inhalers) should be carried by the camper, however, medical personnel should be notified when medication administration is required.

Medication_____________________________ Dosage_________________ Take at what times__________________
Reason for Taking____
Prescribing Physician____ Phone____________________________

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Reason for Taking____
Prescribing Physician______________________________________ Phone_____________________________

I, ________________________________, the parent or guardian of _____________________________ authorize Teenage Christian Camp to administer the following over the counter medications as needed for minor symptoms: (Please circle)

Benadryl Tylenol Ibuprophen Pepto Bismol Tums

Pseudoephedrine Claritin Loratadine

Please list any over the counter medications that should not be administered to the above named camper:

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SECTION IV – ALLERGIES

_____ Camper does not have any allergies

_____ Camper is allergic to:

Please list allergy. Describe reaction and treatment

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SECTION V – IMMUNIZATIONS

_____ Camper is up to date on immunizations

SECTION VI – HEALTH HISTORY

Please know that we value your privacy. Health History information is available only to the camp health staff.

Does the camper have a history of or is prone to any of the following (Please check all that apply).

1. Recent injury or illness
2. Chronic or recurring illness
3. Asthma
4. Homesickness
5. Frequent Ear Infections
6. Seizure Disorder or Convulsions
7. Dizziness during or after exercise
8. Chest pain during or after exercise
9. Heart Defect/Disease
10. Hypertension
11. Bleeding/Clotting Disorders
12. Diabetes
13. Mononucleosis (in last 12 months)
14. Chicken Pox
15. Measles
16. German Measles
17. Mumps
18. Tuberculosis
19. Hepatitis
20. Joint problems (knees, ankles)
21. Fractures
22. Migraines
23. Head Injury
24. Eating Disorder
25. Stomachaches
26. Glasses/ contacts

Please list the number and provide explanation for any checked items

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SECTION VII – AUTHORIZATION

My child has permission to engage in all prescribed camp activities except as noted. The information provided on this form is accurate to the best of my knowledge. I have indicated any special health conditions, including required medication and activity limitations which should be known to the camp staff and medical personnel. I am aware of and accept the risk inherent in the program activity. I give consent in advance for medical treatment at an appropriate facility in case of illness or injury.

Signature of Parent or Guardian X___________________________________ Date___________________