

2012 UNITED METHODIST HEALTH HISTORY & TREATMENT AUTHORIZATION

Camper's Name _____

Camp # _____ Birthdate ____ / ____ / ____

Social Security # _____ - _____ - _____

Date of camper's last tetanus shot ____ / ____ / ____

All campers, regardless of health, must MAIL this completed and signed form WITH THE REGISTRATION FORM. **The camper will not be admitted to camp or travel without it.** Confidentiality will be honored. Be sure to copy both sides of this form when making additional copies. For further explanation of answers, use additional paper as needed and attach.

Please list all medications on the opposite side of this form.

Camper History: Please check/circle all that apply:

- Chronic infection of throat
- Chronic infection of ears
- Chronic infection of sinus
- Chronic infection of lungs
- Chronic infection of urinary tract
- Fainting
- Nose bleeds
- Cramps
- Heart condition
- High blood pressure; is it controlled? **Y N**
- Diabetes; is it controlled? **Y N**
- Seizure; is it controlled? **Y N**
- Epilepsy; is it controlled? **Y N**
- Sleep Walking
- Asthma or other breathing conditions
- Chronic digestive or gastric complaints
- Bed wetting or bladder control
- Anxiety
- Hyperactivity
- ADD or ADHD
- Violent or aggressive behaviors

Please explain: _____

Please circle "Y"(yes) or "N"(no) for each of the following:

- Y N** Camper can walk up and down stairs easily
- Y N** Camper has been recently exposed to a contagious disease
If yes please identify:
- Y N** Camper has tubes in the ear. If yes which ear(s)?
- Y N** Camper has a skin disease. If yes please identify:
- Y N** Camper has experienced unusual stress or trauma.
If yes please explain:
- Y N** Is there a physical, mental, psychological, spiritual or social condition requiring restricted activities or special assistance?

If yes to any, please explain: _____

Allergies and Dietary needs:

Does camper require a diabetic diet? **Y N**

Please list all allergies including those to food, medications and environment.

Immunizations:

____/____ Hepatitis A
 Please give the date of the most recent (month/year if possible.) ____/____ MCV4 (Meningococcal)
 ____/____ Hepatitis B
 ____/____ Tdap (Tetanus, Diphtheria, Pertussis) ____/____ PPV (Pneumococcal)
 ____/____ IPV (Poliovirus)
 ____/____ Influenza ____/____ Varicella
 ____/____ HPV (Human Papillomavirus) ____/____ MMR

Name (print) _____

Date ____/____/____

Relationship to Camper _____
 ("parent", "legal guardian" or "self")

Family Medical Insurance Company _____

Name of Insured _____

Policy # _____ Group # _____

Physician _____

Phone (_____) _____

I understand that camp staff need to know pertinent information about the camper's mental and physical health. Therefore, I have disclosed all information that could jeopardize the camper's health and safety or the safety of others. Failure to disclose information could require my child to be sent home from camp.

I give permission to the camp to provide routine health care, administer prescribed and over-the-counter medications, seek emergency medical treatment including ordering x-rays and routine tests, and arrange necessary related transportation.

I agree to the release of any records necessary for insurance purposes. In the event I cannot be reached (or cannot respond if an adult camper) in case of an emergency, I give permission to the physician(s) selected by the camp staff to secure and administer proper treatment, including hospitalization, for the above-named person and to release information regarding said medical treatment to camp staff.

Unless otherwise indicated, I release all rights to photos taken at camp solely for purposes of promotion by the Kansas East Annual Conference.

Signature _____

(parent, legal guardian or adult camper)