RETREAT

CROSSWAYS
CAMPING MINISTRIES

ADULT HEALTH HISTORY FORM

Please check which camp you are attending: ☐ Imago Dei Village ☐ Pine Lake ☐ Waypost

Name: ____

First Middle Last

Dates will attend camp: from ______________________________ to ___________________________________

(Month/Day/Year) (Month/Day/Year)

Group/Congregation attending with: ____

Birthdate:__________________________________ Age on arrival at camp: ____________ ❒ Male ❒ Female

(Month/Day/Year)

I further authorize Crossways Camping Ministries to use photos, videos or other likeness of the above named for Crossways publicity with no identifying information posted. Please initial here if you **DO NOT** authorize this use: ____________

Please follow the instructions below. Attach additional information if needed.

1) **Complete all pages of this form and make a copy to keep for your records (for future retreats).**
2) **Bring this original, completed and signed form to camp with you.**

Home Address: ____

Street Address City State Zip Code

Emergency contact to be contacted in case of illness or injury:

Name: ______________________________________ Relationship: ____________________________

Preferred Phones: (_____) ______________________________ (_____) ______________________________

Email: ____________________________________

Home Address: ____

Allergies:

❒ No known allergies.
❒ I am allergic to: ❒ Food ❒ Medicine ❒ The environment (insect stings, hay fever, etc.)
❒ Other
(*Please describe below what you are allergic to and the reaction seen.)*

Diet, Nutrition:

❒ I eat a regular diet. ❒ I eat a regular vegetarian diet.
❒ I am lactose intolerant. ❒ I am gluten intolerant.
❒ Other, ***please explain in space.***

Restrictions:

❒ I have reviewed the program and activities of the camp and feel I can participate without restrictions.
❒ I have reviewed the program and activities of the camp and feel I can participate with the following restrictions or adaptations.
(*Please describe below.)*

Medical Insurance Information:

I am covered by family medical/hospital insurance ❒ Yes ❒ No
Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company: ______________________________________ Policy Number: ________________________

Subscriber: __________________________________ Insurance Company Phone Number: (_____) ________________

Last Revised 8/5/2016

Medication:
❐ I will not take any daily medication while attending camp.
❐ I will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies.

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			❐ Breakfast ❐ Lunch ❐ Dinner ❐ Bedtime ❐ Other time:		

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.
Have/do you:

1. Ever been hospitalized?....... ❐ Yes ❐ No
2. Ever had surgery?....... ❐ Yes ❐ No
3. Have recurrent/chronic illnesses?….... ❐ Yes ❐ No
4. Had a recent infectious disease?....... ❐ Yes ❐ No
5. Had a recent injury?….... ❐ Yes ❐ No
6. Had asthma/wheezing/shortness of breath?….... ❐ Yes ❐ No
7. Have diabetes?….... ❐ Yes ❐ No
8. Had seizures?….... ❐ Yes ❐ No
9. Had headaches?….... ❐ Yes ❐ No
10. Wear glasses, contacts, or protective eyewear?….... ❐ Yes ❐ No
11. Had fainting or dizziness?….... ❐ Yes ❐ No
12. Passed out/had chest pain during exercise?….... ❐ Yes ❐No
13. Had mononucleosis ("mono") during the past 12 months?….... ❐ Yes ❐ No
14. If female, have problems with periods/menstruation?….... ❐ Yes ❐ No
15. Have problems with falling asleep/sleepwalking?….... ❐ Yes ❐ No
16. Ever had back/joint problem?….... ❐ Yes ❐ No
17. Have problems with diarrhea/constipation?….... ❐ Yes ❐ No
18. Have any skin problems?….... ❐ Yes ❐ No
19. Traveled outside the country in the past 9 months?….... ❐ Yes ❐ No

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

Health-Care Providers:
Name of primary doctor(s): ____ Phone: (_____) __________________________

Name of dentist(s): ____ Phone: (_____) __________________________

Name of orthodontist(s): ____ Phone: (_____) _________________________

What Have We Forgotten to Ask? ***Please provide in the space below*** any additional information about your health that you think is important or that may affect your ability to fully participate in the camp program. ***Attach additional information if needed.***