



## 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: (\_\_\_\_) \_\_\_\_\_

**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
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time:		

**General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.**

Have/do you:

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