CROSSWAYS
CAMPING MINISTRIES

CAMPER HEALTH HISTORY FORM

Please check which camp your child is attending: ☐ Imago Dei Village ☐ Pine Lake ☐ Waypost

Camper 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: _____

To Parent(s)/Guardian(s): 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) **Send the original, completed and signed form with your child to camp.**

Camper Home Address: _____
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship to Camper: _____

Preferred Phones: (_____) _____ (_____) _____

Email: _____

Home Address: _____

(if different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name: _____ Relationship to Camper: _____

Preferred Phones: (_____) _____ (_____) _____

Email: _____

Additional contact in event parent(s)/guardian(s) cannot be reached:

Name: _____ Relationship to Camper: _____

Preferred Phones: (_____) _____ (_____) _____

Email: _____

Allergies:

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

Diet, Nutrition:

❒ This camper eats a regular diet. ❒ This camper eats a regular vegetarian diet.
❒ This camper is lactose intolerant. ❒ This camper is gluten intolerant.
❒ Other, ***please explain in space***

Restrictions:

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

Medical Insurance Information:
This camper is 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: (_____) _____

Parent/Guardian Authorization for Health Care:
This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.
Signature of Custodial
Parent/Guardian _____ Date: _____

Relationship to Camper: _____
If for religious or other reasons you cannot sign this, contact the camp for a legal waiver, which must be signed for attendance.

Immunization History: Provide the month and year for each immunization. Starred (*) immunizations must include date. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria, tetanus, pertussis (DTaP) or (TdaP)						
Tetanus booster* (dT) or (TdaP)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Haemophilus influenza type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) ❒ Had chicken pox Date:						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date:	❒ Negative ❒ Positive

If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.
Signature of Custodial Parent/Guardian _____ Date: _____

Relationship to Camper: _____

Medication:
❒ This camper will not take any daily medication while attending camp.
❒ This camper 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. ***Many states require original pharmacy containers with labels, which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.***

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:		
			❒ Breakfast ❒ Lunch ❒ Dinner ❒ Bedtime ❒ Other time:		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. ***Cross out those the camper should not be given.***

*Acetaminophen (Tylenol) *Ibuprofen (Advil, Motrin) *Phenylephrine decongestant (Sudafed PE) *Pseudoephedrine decongestant (Sudafed) *Antihistamine/allergy medicine *Guaifenesin cough syrup (Robitussin) *Diphenhydramine antihistamine/allergy medicine (Benadryl) *Dextromethorphan cough syrup (Robitussin DM) *Sore throat spray *Generic cough drops *Lice shampoo or cream (Nix or Elimite)*Antibiotic cream *Calamine lotion *Aloe *Laxatives for constipation (Ex-Lax) *Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

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

Has/does the camper:

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 a history of bedwetting?..... ❒ Yes ❒ No
18. Have problems with diarrhea/constipation?..... ❒ Yes ❒ No
19. Have any skin problems?..... ❒ Yes ❒ No
20. 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.

Mental, Emotional, and Social Health: *Check "Yes" or "No" for each statement.*

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?..... ❒ Yes ❒ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?..... ❒ Yes ❒ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?..... ❒ Yes ❒ No
4. Had a significant life event that continues to affect the camper's life? ?..... ❒ Yes ❒ No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Health-Care Providers:

Name of camper's 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 the camper's health that you think is important or that may affect the camper's ability to fully participate in the camp program. ***Attach additional information if needed.***