

Health Form 2010



This form is due at camp **at least 2 weeks prior** to attendance.

Asbury Hills Camp & Retreat Center
Attn: Health Forms
150 Asbury Drive
Cleveland, SC 29635

FAX: 864.836.5522
Email: office@asburyhills.org
Phone: 864.836.3711

Name _____ Dates Attending Camp _____

 Last First Middle
Grade Entering in Fall _____ Age at camp _____ Birth date _____ Event Name _____

Home Address _____
 Street City State Zip

Social Security Number of participant _____ Gender: Male Female

Custodial parent/guardian _____ Phone _____

Home Address _____
(If different from above) Street City State Zip

Cell Phone _____ Business Phone _____

Second parent, guardian, or emergency contact _____

Address _____ Phone _____
 Street City State Zip

Cell Phone _____ Business Phone _____

If not available in an emergency, notify:

Name _____ Relationship _____

Address _____ Phone _____
 Street City State Zip

Insurance Information

Is participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name _____ Group # _____

◆◆◆Photocopy of front and back of health insurance card must be attached to this form.◆◆◆

Name of family physician _____ Phone _____

Name of family dentist/orthodontist _____ Phone _____

Name of Medical Specialist _____ Phone _____

IMPORTANT—THIS BOX MUST BE COMPLETE FOR ATTENDANCE

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

Permission to Provide Necessary Treatment or Emergency Care:

I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. *(The completed forms may be photocopied for trips out of camp and for doctor and emergency room use).

1. I have read the instructions for the parents and give permission for the medical staff to provide treatment in the infirmary for accidents or illness according to policies and procedures of the camp.
2. I have provided any written instructions necessary for the medical personnel on this health form.
3. I also give permission to the medical personnel to administer over the counter medications (as listed on page 2) as deemed appropriate according to the camper's complaints or condition.
4. I understand that my designee or I must be available to pickup my camper during their time at camp should a medical or behavioral problem arise.
5. *Note: Parents will be contacted if the camper has an illness or accident that is of concern to the Health Officer and Director. Parents will be contacted/consulted in the event that a trip to Urgent Care, Emergency Room, or other off site medical attention is necessary. In the event that the parents cannot be reached, the Health Officer or Director will try to reach an Emergency Contact Person.

Signatures of all custodial parents or legal guardians, or of adult event participant/staffer _____

Please Print Name(s) _____ Date _____

Camper Name _____ Dates Attending Camp _____
(Please Print) Last First

Health History

The following information must be filled in by the parent/guardian, or adult camper or staff member. The intent of this information is to provide appropriate care. Please keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon arrival at camp. This information will be shared with your child's counselor. Please provide complete information you feel may be helpful to them. **All questions and blanks MUST be filled in or answered with at least "Yes", "No" or "N/A".**

Allergies (List all known)

Describe reaction and management of the reaction.

Medication Allergies, Food Allergies and Other Allergies (list, including insect stings, hay fever, asthma, ivy poisoning, animal dander, etc.).

_____	_____
_____	_____
_____	_____
_____	_____

Restrictions

Please list any dietary restrictions that apply to this individual (e.g. vegetarian, lactose intolerance, etc.).

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary).

What fears or concerns should we assist your child in dealing with (e.g. homesickness, sleepwalking, etc.)?

Over The Counter Medications (if you do not want your child treated with any of the following while at camp, cross it off and initial)

Camper Complaint

Medicine Administered (May be generic equivalent)

Minor aches & pains, headaches, toothaches or elevated temperature	Motrin or Tylenol
Itching, rash, poison ivy, insect bites or sunburn	Benadryl, Calamine, Aveno, 1% Hydrocortisone Cream, Aloe
Mild diarrhea (w/o other symptoms)	Imodium
Upset stomach	Tums, Pepto Bismal
Minor cuts, scratches, abrasions	Triple antibiotic (Neosporin), Sterile Wipes
Mosquito, insect bites	Insect repellent, Skeeter Stik, After Bite
Itchy, watery eyes, sneezing, runny nose	Benadryl tablet
Stuffy nose	Sudafed
Sore throat	Throat lozenges
Sun exposure	Sunscreen

The following person(s) is (are) authorized to pick up my child at the completion of camp:

(Please Print) _____

Camper Pick Up:

Released to _____ Counselor _____ Date _____

Camper Name _____ Cabin _____
(Please Print) Last First (Office Use Only)

*****Please note: A photo ID will be required at the time of pick-up***
Please bring this with you to the closing ceremony.**

Medication Being Taken Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. All medications, including over-the-counter/nonprescription, must be turned in to the Health Officer at registration.

- This person takes NO medications on a routine basis.
- This person takes medications as follows:
 Med #1 _____ Dosage _____ Specific times taken each day _____
 Reason for taking _____
 Med #2 _____ Dosage _____ Specific times taken each day _____
 Reason for taking _____
 Med #3 _____ Dosage _____ Specific times taken each day _____
 Reason for taking _____

Attach additional pages if needed. **Identify any medications** taken during the school year that the participant does/may not take during the summer:

Which of the following has the camper had?	Please give all dates of immunization for:						
<input type="checkbox"/> Measles	Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
<input type="checkbox"/> Chicken pox	DTP		_____	_____	_____	_____	_____
<input type="checkbox"/> German measles	TD (tetanus/diphtheria)		_____	_____	_____	_____	_____
<input type="checkbox"/> Mumps	Tetanus		_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis A	Polio		_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis B	MMR		_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis C	or Measles		_____	_____	_____	_____	_____
<input type="checkbox"/> Rheumatic Fever	or Mumps		_____	_____	_____	_____	_____
<input type="checkbox"/> TB Mantoux Test	or Rubella		_____	_____	_____	_____	_____
Date of last test _____	Haemophilus influenza B		_____	_____	_____	_____	_____
Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Hepatitis B		_____	_____	_____	_____	_____
	Varicella (chicken pox)		_____	_____	_____	_____	_____
	Other (specify) _____		_____	_____	_____	_____	_____

General Questions (Explain "yes" answers below.)

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Had any recent injury, illness or infectious disease?..... | <input type="checkbox"/> | <input type="checkbox"/> | 19. Have any skin problems (e.g. itching, rash, acne)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have a chronic or recurring illness/condition?..... | <input type="checkbox"/> | <input type="checkbox"/> | 20. Have diabetes?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ever been hospitalized?..... | <input type="checkbox"/> | <input type="checkbox"/> | 21. Have asthma?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Ever had surgery?..... | <input type="checkbox"/> | <input type="checkbox"/> | 22. Had mononucleosis (mono) in the past 12 months?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have frequent headaches?..... | <input type="checkbox"/> | <input type="checkbox"/> | 23. Had problems with diarrhea/constipation?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Ever had a head injury?..... | <input type="checkbox"/> | <input type="checkbox"/> | 24. Have problems with sleepwalking?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ever been knocked unconscious?..... | <input type="checkbox"/> | <input type="checkbox"/> | 25. If female, has she menstruated?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Wear glasses, contacts or protective eyewear?..... | <input type="checkbox"/> | <input type="checkbox"/> | a) If no, has she been told about it with instructions?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Had frequent ear infections?..... | <input type="checkbox"/> | <input type="checkbox"/> | b) If yes, does she have an abnormal menstrual history?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Ever passed out during or after exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> | 26. Have a history of bedwetting?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Ever been dizzy during or after exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> | 27. Ever had an eating disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Ever had seizures?..... | <input type="checkbox"/> | <input type="checkbox"/> | 28. Ever had emotional difficulties for which professional help was sought?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Ever had chest pain during or after exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> | 29. Ever had problems with homesickness?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Ever had high blood pressure?..... | <input type="checkbox"/> | <input type="checkbox"/> | 30. Can the camper swim?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Ever been diagnosed with a heart murmur?..... | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 16. Ever had back problems?..... | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 17. Ever had problems with joints (e.g. knees, ankles)?..... | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 18. Have an orthodontic appliance being brought to camp?..... | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Please explain any "yes" answers, including dates where applicable, noting the number of the questions.

Use this space to provide any additional information about the camper's behavior and physical, emotional, or mental health about which the camp should be aware.
