



Camper Health Form*

Full Name: _____ Camp Code: _____ Date: ___/___/___

Birth date: _____ Gender: Male Female

List three names, their relationship to the camper, and phone numbers of whom to contact in case of an emergency:

1. _____
2. _____
3. _____

HEALTH-CARE PROVIDERS:

Primary care physician: _____ Phone number: (_____) _____

Dentist: _____ Phone number: (_____) _____

Other (specify): _____ Phone number: (_____) _____

INSURANCE:

This camper is covered by family insurance: YES NO

If yes, include a copy of both sides of the insurance card.

Insurance company: _____ Policy number: _____

Subscriber: _____ Insurance company phone number: (_____) _____

HEALTH INFORMATION:

Allergies: No known allergies OR allergic to: _____

This camper has been fully immunized: Yes No Date of last Tetanus: ___/___/___

Circle yes or no if this camper has or had the following. If yes, explain below.

Been hospitalized?	Yes	No	Recent Injury?	Yes	No	Headaches?	Yes	No
Had Surgery?	Yes	No	Shortness of Breath?	Yes	No	Fainting or Dizziness?	Yes	No
Chronic Illness?	Yes	No	Diabetes?	Yes	No	Chest Pain?	Yes	No
Infectious Disease?	Yes	No	Seizures?	Yes	No	Back/Joint Problems?	Yes	No
Bedwetting?	Yes	No	Skin Problems?	Yes	No	Trouble sleeping?	Yes	No
Diarrhea Problems?	Yes	No	Wear glasses or contacts?	Yes	No	Eating Disorder?	Yes	No
Constipation Problems?	Yes	No	Sleepwalking?	Yes	No			

If female, have problems with menstruation? Yes No

Treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? Yes No

Have mental, emotional, or behavioral concerns? Yes No

Had a significant life event that continues to affect the camper's life? Yes No

Has food restrictions or has special dietary needs? Yes No

Continued >>>

* Even leaders, deans, and otherwise are considered campers and need to fill this form out to complete the registration process.

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Full name: _____ Camp Code: _____

Explain yes answers from the previous page here: _____

Does this camper have Asthma? Yes No If yes...

Will the camper carry a rescue inhaler? Yes No Need assistance with inhaler? Yes No

MEDICATION:

Will this camper take any daily medications while at camp? Yes No

List the medications the camper will be taking:

Name of Medication	Reason given	When is it given?	Dose to give?	How is it given?

Non-prescription medications may be stocked at the camp and are used on an as needed basis to manage illness and injury. Can this camper use over the counter medications and/or bandages? Yes No

What have we forgotten to ask? Is there anything else we should know about this camper? _____

I agree to abide by all the rules and policies of camp and to live cooperatively with other campers and leaders.

Camper's Signature: _____ Date: ____/____/____

My signature below indicates that:

- I agree to hold the Oklahoma United Methodist Camp and Retreat Program and all leaders of this camp free from liability for any injuries, damages or losses unless caused by the willful or intentional conduct on the part of the leader or staff.
- I hereby give permission to the physician or hospital staff selected by the camp leadership to order X-rays, routine tests, and treatment for the health of the camper.
- In the event I cannot be reached in an emergency, I hereby give permission to the physician or hospital staff selected by the camp leadership to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for this camper.
- This camper has permission to engage in camp activities, agrees to participate fully in the features of the program and cooperate in maintaining an atmosphere of Christian fellowship.
- I consent to the use of this camper's image or voice in photographs, audio and/or video recording taken during the course of this camp for the purpose of publicizing the camping program of the Oklahoma Conference of the United Methodist Church.

Parent/Guardian's Signature: _____ Date: ____/____/____

(if the camper is an adult, then their signature)

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