

HEALTH HISTORY FORM • CHILDREN/YOUTH/FAMILY

Outdoor & Retreat Ministries of Northern Illinois Conference

Please send completed Registration, All About Me, and this Health Form (front and back) to the address listed below at least 2 weeks prior to your arrival so that the camp staff can be aware of your needs. Attach additional pages if needed. Any changes to this form should be provided to camp health personnel in writing upon participant's arrival in camp.

Dates of Camp Attendance _____

Name of Camp Event _____

Camper's Name: _____ Gender: M F
Last First Middle Int.

Birthdate ____/____/____ Age at time of camp _____ Grade entering in Fall: _____

Mailing Address: _____ City: _____ State _____ Zip: _____

Parent/Guardian Name(s): _____

Home Phone _____ Work Phone _____ Cell Phone _____

Address (if different from camper) _____ City: _____ State _____ Zip: _____

If parent is not available in an emergency, notify: _____

Address _____ Phone _____ Other Phone _____

City _____ State _____ Zip _____ Relationship to Camper _____

Does camper have any known allergies? Yes No

Allergies to medications: _____

Food allergies: _____

Other allergies: _____

List any dietary restrictions: _____

Health History: (Check any that apply)

<input type="checkbox"/> Epilepsy or seizures	<input type="checkbox"/> Frequent ear infections	<input type="checkbox"/> Menstrual problems	<input type="checkbox"/> Asthma
<input type="checkbox"/> Frequent sore throats	<input type="checkbox"/> Headaches	<input type="checkbox"/> Bed-wetting	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Back pain or strain	<input type="checkbox"/> Alcohol/drug addiction	<input type="checkbox"/> Attention Deficit Disorder	<input type="checkbox"/> Diabetes

Other: _____

Pertinent past medical treatment: _____

Is camper presently taking or using any type of medication(s) or drug(s)? Yes No

If yes, Specify and complete med report on reverse side:

Is camper current on all immunizations needed for school? Yes No

Date of last Tetanus shot: _____ Blood Type (if known) _____

Does the camper have a health condition (e.g. allergies, chronic conditions) or special circumstances which may affect program participation, special housing need, or anything we ought to know prior to emergency treatment? Yes No

If yes, please explain:

• • • • •

Family Medical Insurance: Yes No Name of Insured _____

Carrier: _____ Group # _____ Policy # _____

Name of Family Physician _____ Phone _____

Parent/Guardian Authorization:
 My child has permission to take part in all camp activities under supervision unless limitations are noted above, and I agree that the camp or camp personnel will not be held responsible for accidents arising there from. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for my child.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, injection, surgery and anesthesia for the person named above. This completed health form may be photocopied for trips out of camp.

Signature of Parent/Guardian _____ Date _____

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Permission to Administer Medications

I, the parent or guardian of _____ gives my permission to the camp Health Care Provider or his/her designate to give the following medications (or the generic equivalents) to my child, in accordance with recommended package dosing for the specific indications below. These medication are available at camp and need not be brought by participants.

	Yes	No		Yes	No
Tylenol: Mild fever or discomforts	<input type="checkbox"/>	<input type="checkbox"/>	Benadryl: Allergy symptoms	<input type="checkbox"/>	<input type="checkbox"/>
Ibuprofen: Mild fever or discomforts	<input type="checkbox"/>	<input type="checkbox"/>	Sudafed: Allergy symptoms	<input type="checkbox"/>	<input type="checkbox"/>
Throat Lozenges: Coughs/sore throat	<input type="checkbox"/>	<input type="checkbox"/>	Antacid: Upset stomach	<input type="checkbox"/>	<input type="checkbox"/>
Topical Creams: Itching, sunburn Or insect bites	<input type="checkbox"/>	<input type="checkbox"/>	Anti-diarrheal: For diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Permission to follow recommendations by local Poison Control Centers	<input type="checkbox"/>	<input type="checkbox"/>			

Signature of Parent/Guardian _____ Date _____

Please describe any current physical, mental, or psychological conditions requiring medication, treatment, or special restrictions or considerations while at camp: _____

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.

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 _____

All medications brought to camp MUST be in their original containers.

NOTE: The camp personnel will notify you if your child displays the following symptoms:

- Any illness that persists longer than 24 hours; including fevers, coughs, excess expulsion of bodily fluids, allergic reactions, severe tiredness.
- Any injury that causes severe prolonged pain, discolorization and/or swelling.
- Any condition that cannot be sufficiently treated by camp personnel.
- Any condition requiring transport to other medical services.

Physical and doctor signature no longer required by ORM.

Upon camper check-in:	
Health History Form Verified _____	by _____
Date	Name or Initials
Health History Form Updated _____	by _____
Date	Name or Initials