



Health History for Camp Christian

10335 Maple Dell Rd, Marysville, Oh 43040

For Ribbit, Otter, Chi Rho & CYF Camps



This form must be mailed, faxed or emailed in to the Regional Church Office before the corresponding Camp or Conference

PLEASE PRINT

Camper Name _____ Date of Birth _____ Gender _____
last first middle

Address _____ Home Phone (_____) _____
street city state zip

Parent/Guardian _____ Cell Phone (_____) _____

Relationship _____ Email _____ Work Phone (_____) _____

Additional Emergency Contact _____ Cell Phone (_____) _____

Relationship _____ Email _____ Work Phone (_____) _____

Primary Physician _____ Office Phone (_____) _____

ALLERGIES

List allergies and describe reaction/management for each of the following

Camper has NO allergies

Allergies to medications _____

Allergies to food or dietary restrictions (i.e. vegetarian, no peanuts, no dairy) **Severity :** Mild Severe Airborne

All other allergies (i.e. insect/bee stings, environmental, latex) _____

IMMUNIZATIONS

I attest that my child has received all required immunizations needed by school, and they are all up to date.

Parent/Guardian: _____

Please indicate the date of your campers most recent Tetanus Booster: _____ Not Sure

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.

Parent/Guardian: _____
Date: _____ Relation: _____

HEALTH HISTORY

Check if camper has:

- | | |
|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Bedwetting concern | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bleeding/Clotting Disorder | <input type="checkbox"/> Sleep walking concern |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Severe allergic reaction |
| Inhaler Sent? Yes <input type="checkbox"/> No <input type="checkbox"/> | Epi-Pen Sent? Yes <input type="checkbox"/> No <input type="checkbox"/> |

Additional explanation of above if necessary

Please tell us of any current physical, mental, or psychological conditions that would require restrictions or special attention to any activities while at camp _____

MEDICAL INSURANCE INFORMATION

Insurance Company _____ Insurance Company phone (_____) _____

Insurance company address _____
street city state zip

Subscriber's Name _____ Employer _____ DOB _____

Relation to Camper _____ Contract or Identification number: _____ Group number: _____

Continued on the next page

Over the Counter Medications: The following non-prescription medications are stocked by the camp and are used on an as needed basis to manage illness and injury. **Cross out those that the camper should not be given.**

Acetaminophen (Tylenol)
 Hydrocortisone cream
 Generic cough drops / Throat Spray
 Bismuth subsalicylate (Pepto-Bismol)

Antihistamine/allergy medicine (Benadryl)
 Triple antibiotic ointment
 Laxative (Ex-Lax)

Calamine lotion
 Ibuprofen (Advil, Motrin)
 Calcium carbonate (Tums)

Medications

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.

This camper will not take any daily medications while attending camp
 This camper will take the following daily medications while at camp
(Complete the chart below – attach additional page if necessary)

Medication	Date started	Reason for taking it	When it is given	Amount/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: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		

Treatment Authorization: The information on this form is correct and complete so far as I know. The person described herein has permission to participate in all camp activities except those noted. I hereby give permission to Camp Christian to transport my child to an Emergency Room, and in the same event I also give permission to the physician selected or assigned to order X-rays, routine tests, 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 for any of the following activities as it pertains to my child named above: hospitalization, securing proper treatment, or ordering injection, anesthesia or surgery. I understand the information on this form will be shared on a “need to know” basis with camp staff. 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 **Parent/Guardian** _____
Date

Participant Agreement: Camp Christian has informed me that this program is not without risks. Certain risks are inherent in outdoor programs and cannot be eliminated. Although it is impossible to foresee all risks, some risks include tripping, falling, sunburn, hot/cold temperature extremes, poison ivy, fire-centered activities, scrapes, bruises, bites, stings, blisters, and getting lost. Camp Christian has bodies of water including a lake and 2 swimming pools and, although participants are not allowed near them without supervision, the water’s presence does present the risk of drowning. The participation of my child is completely voluntary, and I agree for my child to participate in spite of the risks. I agree to assume responsibility for the risks identified herein and those risks not specifically identified.

I agree that my child is fully capable of participating in this program. Therefore, I assume and accept full responsibility for my child’s bodily injury, death, loss of personal property, and also loss or damage to any camp property and any expenses as a result of those inherent risks identified herein and those inherent risks not specifically identified, and, as a result of my child’s participation in this program. I understand and am aware that participation in the program by my child will include many physical activities and the potential for accidents does exist. I agree that my private health insurance will be utilized as the primary health insurance coverage in the event of an accidental injury. I understand the possible risks associated with an outdoor program, assume these risks for my child and hold blameless Camp Christian, any affiliated persons or entities, and all of its employees and associates. As the parent/guardian, I further agree that should my child become ill or injured or demonstrate repeated or severely inappropriate or unsafe behavior, I, or someone representing me, will come to Camp Christian to transport my child home.

I have carefully read and clearly understand what is written above. I accept the terms and conditions stated herein and acknowledge that this agreement shall be effective and binding upon all heirs, assigns, personal representative estate, and myself and for all members of my family, including minor children.

 Printed Name of **Camper** _____
Signature of **Camper**

 Printed Name of **Parent/Guardian** _____
Signature of **Parent/Guardian**

Return this form before the corresponding Camp/Conference to:
 NEW ADDRESS - Christian Church in Ohio, 1347 Worthington Woods Blvd., Suite A, Worthington, OH 43085
 You may also fax to 614-433-7285 or email to ccio@ccinoh.org.