

PROGRAM HEALTH AND CONSENT FORM

Camp Attending: _____



Event Attending: _____

Dates: _____

TO BE COMPLETED FOR ALL PERSONS USING CAMP:

Camper Name: _____ Date of birth: _____ Sex _____ Age _____
Parent/guardian: _____ Parent/guardian: _____
Home address: _____ City: _____ State: _____ Zip _____
Home phone: (_____) _____ Cell Phone: (_____) _____
Work phone: (_____) _____ E-mail: _____
Emergency contact: _____ Emergency phone: (_____) _____
Primary doctor: _____ Phone: (_____) _____
Health insurance provider: _____ Group policy #: _____
Policyholder: _____ Policyholder's #: _____

PLEASE SELECT APPLICABLE HEALTH INFORMATION:

ALLERGIES *	PHYSICAL		
<input type="checkbox"/> Medication	<input type="checkbox"/> A.D.D. or A.D.H.D	<input type="checkbox"/> Cardiac History	<input type="checkbox"/> Seizures
<input type="checkbox"/> Food	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Sleepwalking
<input type="checkbox"/> Insect sting	<input type="checkbox"/> Bed wetting	<input type="checkbox"/> Homesickness	<input type="checkbox"/> Special diet: _____
<input type="checkbox"/> Seasonal			
<input type="checkbox"/> Other: _____		Treatment for allergic reaction: _____	

* Allergy specifics: _____

ADDITIONAL HEALTH CONDITIONS

Describe any current physical, mental, or psychological condition which require medication, treatment, or special restrictions or considerations at camp (if none, please indicate). _____

IMMUNIZATIONS:

All immunizations for school are up to date: (circle one) **Yes** **No** Date of last tetnus shot: _____

MEDICATIONS:

Are you on any medications?: (circle one) **Yes** **No** *If taking medications at camp, please provide a Physician's Authorization Form.*

Please list all current medications: _____

IMPORTANT MEDICATION INFORMATION:

ANY MEDICATION BROUGHT TO CAMP MUST BE AUTHORIZED BY WRITTEN INSTRUCTIONS AND IS TO BE GIVEN TO AND ADMINISTERED BY CAMP STAFF. ALL MEDICATIONS MUST BE BROUGHT TO CAMP IN THE ORIGINAL CONTAINER IN WHICH THEY WERE ISSUED (WITH MEDICAL INSTRUCTIONS AND DOCTOR'S NAME INTACT). OTHER CONTAINERS WILL NOT BE ACCEPTED. *NOTE: Please only bring the correct amount of medication needed for the duration of the camper's stay. All medication must be given directly to the camp nurse at registration and picked up by the parent/guardian at the end of camp. Campers may carry epipens/rescue inhalers if aithorized by a physcian.*

MEDICAL RELEASE

I hereby give consent for my child to participate in all camp activities and receive routine and/or emergency medical care. In the event of a medical emergency, I understand every effort will be made to contact me. If I cannot be reached, I give my permission to the physician selected by CRISTA Camps to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child.

HEALTH INFORMATION RELEASE

I hereby give consent for information about my child's health may be left in a phone message for the home/cell/work phone numbers listed above.

PARENT/GUARDIAN Signature: _____ Date: _____

