



# **WPAUMC**

## ***Camping and Retreat Ministries***

***Health History and Medical Information Form  
for Children, Youth and Adults Attending Camp***

Camper's Name _____	Event # _____
First	Last

***I/We as parent(s)/guardian(s), hereby agree to allow the sharing of any information contained in this form as regards myself/my child. I realize this will be done with the utmost discretion and by the sharing will provide the best and safest camp experience for myself/my child.***

***Signature \_\_\_\_\_ Date \_\_\_\_\_***

***Jumonville Campers: Please mail this form to Jumonville 1 week before your camp event date.***

***Camp Allegheny & Wesley Woods Campers: Please bring this completed form with you to camp registration.***

**Camper's Name** \_\_\_\_\_

Gender: Male  Last \_\_\_\_\_ Female  Birth date \_\_\_\_\_ First \_\_\_\_\_ Age at camp \_\_\_\_\_ Middle \_\_\_\_\_

Home address \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Custodial parent/guardian** \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Home address \_\_\_\_\_  
(if different from above) Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Business Name \_\_\_\_\_ Business/Cell phone (\_\_\_\_) \_\_\_\_\_

Business Address \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Second parent or guardian or emergency contact** \_\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Business address \_\_\_\_\_ Business/Cell phone (\_\_\_\_) \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**If the above are not available in an emergency, notify** \_\_\_\_\_

Relationship \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**Insurance Information**

Is the participant covered by family medical/hospital insurance? Yes  No   
If so, indicate carrier or plan name \_\_\_\_\_ Group # \_\_\_\_\_

**HEALTH HISTORY**

**ALLERGIES:** List all known. Describe reaction and management of the reaction.

Medication allergies (list) \_\_\_\_\_  
\_\_\_\_\_

Food allergies (list) \_\_\_\_\_  
\_\_\_\_\_

Other allergies (list)-include insect stings, hay fever, animal dander, etc.  
\_\_\_\_\_  
\_\_\_\_\_

History of any of the following:

Asthma or any breathing problem  Diabetes  Ear infections  Headaches  Seizures

History of homesickness  Recent exposure to Head lice

Please note any other medical history you feel will be helpful \_\_\_\_\_  
\_\_\_\_\_

Camper's Name \_\_\_\_\_ Event # \_\_\_\_\_  
First Last

**MEDICATIONS BEING TAKEN**

Please list ALL medication (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. **Keep ALL medications, both prescription and non-prescription drugs, in their original packaging/containers.**

This person takes **NO** medication 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 \_\_\_\_\_

Please attach additional pages if more medications are taken.  
Identify any medications taken during the school year that participant does/may not take during the summer: \_\_\_\_\_  
\_\_\_\_\_  
List any medications taken during the past six months not currently being taken \_\_\_\_\_  
\_\_\_\_\_

**PHYSICAL/ACTIVITY RESTRICTIONS**

The following restrictions apply to this individual \_\_\_\_\_  
\_\_\_\_\_

Explain physical restrictions due to (hospitalizations, accidents, illness, etc.) \_\_\_\_\_  
\_\_\_\_\_

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

**DIETARY RESTRICTIONS**

Does not eat red meat  Does not eat pork  Does not eat poultry  Does not eat eggs  Does not eat seafood  Does not eat dairy  
 Other (describe) \_\_\_\_\_

Are all immunizations up to date  Yes  No

Has camper been exposed to any contagious diseases in the last 4 weeks  Yes  No If yes, to what \_\_\_\_\_

**FOR CAMP USE ONLY:**

Medical/Observation notes Temp \_\_\_\_\_ N&V \_\_\_\_\_ Swimmer's Ear \_\_\_\_\_  
Lice \_\_\_\_\_ Hepatitis Exposure \_\_\_\_\_ Other \_\_\_\_\_  
Has anyone in home/residence been sick in the last 24 hours? \_\_\_\_\_  
INITIALS: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Camper's Name \_\_\_\_\_ Event # \_\_\_\_\_

**Important – These boxes must be complete for attendance\***

This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting in *loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

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, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper/staffer \_\_\_\_\_

Printed Name \_\_\_\_\_ Date \_\_\_\_\_

As parent or legal guardian, I accept the conditions stated, including the release of the W PA UMC and Camp Allegheny, Jumonville and/or Wesley Woods from liability in case of accident or illness. I give permission for the applicant's picture in camp activities to be used in brochures, publications and visual presentations promoting the W PA Camping Ministries, Camp Allegheny, Jumonville and/or Wesley Woods.

Signature of parent or guardian or adult camper/staffer \_\_\_\_\_ Date \_\_\_\_\_

In case of a very traumatic situation, it is a normal procedure to ask a pastor to assist in supporting campers. Please indicate you preference.

Yes, this in fine \_\_\_\_\_ No, thank you \_\_\_\_\_ Other: Please specify \_\_\_\_\_

Pastor Name \_\_\_\_\_ Phone Number \_\_\_\_\_