

ILLNESSES AND INJURIES (*Check those that apply*)

Asthma Convulsions/Seizures Heart Disease/Defect Sickle Cell Disease
 ADD/ADHD Diabetes HIV Tuberculosis
 Bleeding/Clotting Disorder Frequent Ear Infection Hypertension Frequent Upper Respiratory Infections
 Chicken Pox Frequent Sore Throats Kidney Disease Other (Specify) _____

ALLERGIES (*Check those that apply*)

Animals Foods Insect Stings Seasonal/Environmental
 Medications Plants (Poison Ivy, etc) Other (Specify) _____

Please explain any allergies checked above and list treatment if any is necessary:

OTHER HEALTH CONDITIONS (*Check those that apply*)

Athlete's Foot Bed Wetting Constipation Ear Tubes (How protected)
 Emotional Problems Fainting Hearing Impairment Previous Homesickness
 Menstrual Cramps Motion Sickness Nosebleeds Ringworm
 Sleepwalking Stomach Upsets Wears Glasses/Contacts Special Dietary Regimen

Please explain any of above checked items or other conditions not mentioned: _____

CAMPER MEDICATIONS

ALL camper medications will be checked by the Camp Health Supervisor upon arrival. The Health Care Supervisor will insure that medications are administered in accordance with physician's instructions. For these purposes, **Medication** is broadly defined to include prescription and non-prescription medications, home remedies, vitamins, inhalers, drops, and medicated creams. Limited types of common over-the-counter medications are available at each camp. We ask your full cooperation in this matter so that every camper's health and well being can be properly safeguarded. **Please complete one 'Authorization For Medication Administration' form for each medication.** You may copy the form.

- ***NO MEDICATION WILL BE GIVEN WITHOUT THIS COMPLETED MEDICATION FORM!***

****IMPORTANT – THIS BOX MUST BE COMPLETED FOR ATTENDANCE****

CERTIFICATION AND AUTHORIZATION

I certify that the information provided on both sides of this Health History Form is, to the best of my knowledge, complete and accurate. I know of no reason(s), other than the information indicated on this form why my son/daughter should not participate in all camp activities. I take full responsibility for any medical problems (illness or injury) that occur as a result of my failure to disclose medical condition, restrictions, or limitations of my child. I understand the State of Pennsylvania requirement that all campers be examined by the Health Care Supervisor on the day of registration and give my permission for the conduct of such an examination.

My son/daughter _____, has permission to participate in the activities associated with the summer camping program of the Eastern Pennsylvania Conference/United Methodist Church. Further, in the event of an illness or emergency, the Program Center Director or designee is authorized to act in my behalf in securing medical treatment for my child names above.

Signature of Parent/Guardian _____ Date: _____

FOR CAMP USE ONLY:

ON-SITE HEALTH EXAMINATION

General Health Condition: _____

Illness experienced or exposed to during preceding 30 days: _____

Recommendations and restrictions (activity, diet, etc.) _____

Counselor advised of any above conditions: _____

Signature of Camp Health Supervisor: _____ Date: _____