

# Checkpoint Bible Camp Health Record

*This form must be submitted by all campers and staff under 18 years old with the registration form.*

Camper / Staff Name \_\_\_\_\_ Circle: Male Female

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Parent / Guardian Names \_\_\_\_\_

Cell Phone: Father (\_\_\_\_) \_\_\_\_\_ Mother (\_\_\_\_) \_\_\_\_\_

In case of emergency, please notify:

1) \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

2) \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Insurance?  Yes  No Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_ Please attach a photocopy of both sides of insurance card.

### Health History

Are you now, or have you ever been treated for any of the following?

If so, please explain below.

Yes	No	Condition
		Asthma - Last Attack:
		Diabetes
		Hypertension (High Blood Pressure)
		Lung / Respiratory Disease
		Recurring Ear / Sinus Problems
		Muscular / Skeletal Condition
		Psychiatric / Psychological and Emotional Difficulties
		Behavior Disorders (e.g. ADD, ADHD, Asperger Syndrome)
		Bleeding Disorder
		Fainting Spells
		Thyroid Disease
		Kidney Disease
		Sickle Cell Disease
		Seizures – Last Seizure:
		Abdominal / Digestive Problem
		Surgery
		Serious Injury
		Other (Explain):

### Immunizations

If had the disease please put a 'D' in the date column.

Yes	No	Type	Date series completed
		Tetanus	
		Pertussis	
		Diphtheria	
		Measles	
		Mumps	
		Rubella	
		Polio	
		Chicken Pox	
		Hepatitis A	
		Hepatitis B	
		Influenza	
		Meningitis	
		Other	
We choose not to immunize our child. _____			(check if applicable)

**Non-Prescription Medications** - The following non-prescription medications may be administered to your child, if needed, while at camp. *Generic equivalent may be substituted for the name brand medications. All medications will be given according to the label instructions based on age/weight unless otherwise instructed by parent or guardian.*

OK to Administer These Meds?	Yes	No
Tylenol		
Advil / Motrin		
Benadryl		
Robitussin		
Pepto-Bismol (12 yrs. old or older)		
Tums		
Imodium		

Allergies or Reactions	Yes	No	Explain:
Food			
Plants			
Insect Bites			
Medication			
Other:			

Camper/Staff Name: \_\_\_\_\_

Parents or guardians: please list your child's prescription medications, vitamins, herbs, and / or dietary supplements, as ordered by the child's physician. **All medications will be given as directed on the prescription containers. Please explain any differences in instructions.**

**Prescription Medications**

Medication Name	Dosage	Frequency & Indications					Reason for Medication
		Breakfast	Lunch	Supper	Bedtime	Other	

**Over the Counter Medications, Vitamins and Supplements**

Medication Name	Dosage	Frequency & Indications					Reason for Medication
		Breakfast	Lunch	Supper	Bedtime	Other	

**All medications must be in their original containers.** Place all medication containers in a **GALLON SIZE** zip-lock bag, labeled with your child's name, for check-in with the nurses when your camper arrives at camp. A medical attendant will receive medications during camp check-in. Rescue inhalers and epi-pens are the only medications that can be kept with the campers (please send two in case one is lost; one will be checked in with the nurse). **NO PRESCRIPTION MEDICATIONS CAN BE ADMINISTERED UNLESS LISTED ON THIS FORM WITH PARENT OR LEGAL GUARDIAN SIGNATURE. All camper medications must be administered by medical attending personnel.**

Has camper ever required psychiatric counseling or hospitalization? \_\_\_\_\_

Disability or chronic or recurring illness? (date) \_\_\_\_\_

Any specific activity to be LIMITED by physician's advice? \_\_\_\_\_

Dietary modifications: \_\_\_\_\_

Current or history of bedwetting? \_\_\_\_\_

What (if any) details do the camp staff need to know to best meet your camper's needs? (Please write in box below):

I, \_\_\_\_\_, parent or legal guardian of \_\_\_\_\_

Print name (camper or staff name)

authorize the camp medical personnel to administer the medication listed above. I give my permission to release information to designated leader with my child during this week of camp. I authorize the Camp Senior Staff to consent to medical treatment when either I or my assignee cannot be contacted. I understand that every effort will be made to contact me before such action. **A photocopy or electronic reproduction of this signed authorization may be considered valid.**

Signature of parent or legal guardian \_\_\_\_\_ Date \_\_\_\_\_

FOR OFFICE USE ONLY:

Date Received: \_\_\_\_\_ Copy of insurance card: YES or NO (Circle)

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