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
		Faintiing 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) Rev 07/2016