2019 THEME:
Where The Great Commission Meets The Great Outdoors
~Matthew 28:18-20

HIGH C'S FISHING CAMPS REGISTRATION PACKET

HEALTH HISTORY FORMS

Camper's Full Name: _____ Camper DOB: _____ Gender: _____

Health History:
(check and give approximate dates)

_____ Frequent Ear Infection
_____ Heart defect/Disease
_____ Convulsions/Seizures
_____ Diabetes
_____ Bleeding/Clotting Disorder
_____ Hypertension
_____ Mononucleosis
_____ Psychiatric Treatment

Diseases:
_____ Chicken Pox
_____ Measles
_____ German Measles
_____ Mumps

Allergies (dates not needed)
_____ Hay Fever
_____ Poison Ivy
_____ Insect Stings
_____ Penicillin
_____ Sulfa Drugs
_____ Other Drugs
_____ Asthma
_____ Other (specify)

Has this camper ever required any psychiatric counseling or hospitalization?
Explain: _____
Operations or serious injury? (*dates*) _____
Disability or Chronic Illness _____
Activities to be exempt or limited by doctor
_____
Dietary Modifications _____
Current Medications (*Send Instructions*) _____
_____
Other disease or details from above _____
Dentist/Orthodontist Name: _____ Phone: _____
Family Physician Name: _____ Phone: _____
Does your family carrry health insurance? Yes No
If yes, indicate: Company name: _____
Policy or Group Number: _____
Individual who carrries coverage: _____
Suggestions on health related information for camp personal (*attach additional information if necessary*) _____
_____

For Female Campers
Has person menstrated? Yes No
If yes, is her menstrual history normal? Yes No
If no, has she been told about it? Yes No
Special Considerations? _____
_____

Doctor's Report: *(Only required if camper has major health concerns)*
I have examined the persono described and have reviewed his/her history. It is my opinion that he/she is physically able too engage in camp activities, except as noted in the attached report.
Please attach a list of medications to be administered at camp and include specific dosages.

Physician's Name (Print): _____
Physician's Signature: _____
Business Phone: _____ **Home Phone:** _____

HEALTH HISTORY FORM CONTINUED:

VACCINES	YEAR OF BASIC IMMUNIZATION	YEAR OF LAST BOOSTER
Diphtheria Pertussis (Whooping Cough) (DTaP) Tetanus or	1. 2. 3.	1. 2.
Tetanus Diphtheria (Td) or		
Tetanus		
Oral Polio (Sabin) TOPV		
Injectable Polio (Salk)		
Measles, Mumps, Rubella (MMR)		
Varicella (Var)		
Hepatitis B	1. 2. 3.	
Other		
Tuberculin test given _____ (*most recent)*		
Haemophilus influenza b (HIB)		

Consent for Medication Administration

Please circle those medications below that you would allow camp staff to administer to your camper, if needed, and then sign below granting camp staff permission to administer those medications you have circled. If you do not circle one or more of the medications, that medication will not be administered unless staff is able to contact you by phone or in an emergency situation. Please note that all medication s will be given according to labeled directions based upon your child's health history.

Ibuprofen (Advil/Motrin)	Antiseptic Ointment	Aloe Vera
Acetaminophen (Tylenol)	Pepto-Bismol/Tums	Aloe Vera/Burn Cream
Benadryl	Hydrocortisone and/or Calamine	
Sudafed	Cough Drops	

Please Note: For everyone's safety, State Law requires that ALL medications brought to camp be kept by the Camp Director or Health Center. The only exceptions to this rule are rescue inhalers and epi-pens. All medications must be in an original pharmacy container with the correct name, date and instructions on the bottle. The camp cannot give camper any medications that are improperly labeled or not prescribed by a physician/ practitioner. Over-the-counter medications should not be brought to camp by campers unless previously arranged with the Camp Director; camp will have general over-the-counter medications on hand.

This health history is correct so far as I know, and the camper described has permission to engage in all prescribed camp activities, except as noted by me and/or an examining physician. I hereby give permission to the staff and medical personnel to order X-rays, routine tests, treatment and necessary transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp staff or camp nurse to secure and administer treatment, including hospitalization, for my child as named above.

Parent/Guardian Signature: _____ **Date:** _____