



Eastern PA Conference/United Methodist Church

ADULT HEALTH HISTORY FORM

(To be completed and signed by parent/guardian; please print or type all entries)

Completed form must be brought to camp -

PLEASE DO NOT MAIL

For Camp Use Only:

Camp # _____

Housing _____

GENERAL INFORMATION

NAME _____
(Last) (First) (MI)

Social Security # _____ DATE OF BIRTH _____ AGE _____ SEX: M ___ F ___ HEIGHT _____ WEIGHT _____

ADDRESS _____
(Street) (City, State, Zip)

HOME PHONE NUMBER (_____) _____

IN CASE OF EMERGENCY PLEASE NOTIFY:

NAME _____ RELATIONSHIP _____

ADDRESS _____ PHONE (_____) _____

PHYSICIAN'S NAME _____ PHONE NUMBER (_____) _____

FAMILY MEDICAL/HOSPITAL INSURANCE CARRIER

POLICY ID # _____ POLICY/GROUP # _____ POLICY HOLDER'S SSN

(This information is required since each person is covered by limited accident and medical insurance in excess of own insurance; **CAMP'S POLICY IS A SECONDARY POLICY.** PA state law prohibits duplicate payments.)

PLEASE NOTE THAT ALL MEDICATIONS WILL BE CHECKED BY THE CAMP HEALTH CARE SUPERVISOR UPON ARRIVAL.

The Health Care Staff 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. *Adult campers, staff and volunteers may take responsibility for their own medication, however you must adhere to policies regarding safeguarding medications.*

CERTIFICATION AND AUTHORIZATION ** IMPORTANT - THIS BOX MUST BE COMPLETED FOR ATTENDANCE **

I certify that the information provided on both sides of the 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 I 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 conditions, restrictions, or limitations. I understand the State of PA requirement that all campers be examined by the Health Care Staff on the day of registration and give my permission for the conduct of such an examination.

I _____ will 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 me.

Signature _____ Date _____

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TO GIVE APPROPRIATE CARE TO THE CAMPER WHILE HERE AT CAMP, PLEASE COMPLETE THE FOLLOWING INFORMATION ACCURATELY - THANK YOU

DATE OF CAMPER'S LAST HEALTH EXAM _____ WERE ANY PROBLEMS NOTED AT THAT TIME? ___ YES ___ NO
SINCE THE CAMPER'S LAST HEALTH EXAM, HAS HE OR SHE HAD ANY OF THE BELOW:

- A serious injury requiring medical attention ___ Yes ___ No Surgery or a fracture ___ Yes ___ No
A diagnosed infectious disease ___ Yes ___ No Exposed to any communicable disease ___ Yes ___ No
**A physician's restriction in any physical activity ___ Yes ___ No **Medication prescribed ___ Yes ___ No

PLEASE EXPLAIN : _____

** A physical examination may be required to participate in physically active camps. (See camper letter) NO Medication will be given without completed medication forms!

Is the camper currently under a physician's care for a medical problem? (Describe)

Are all immunizations up to date? ___ Yes ___ No Date of last Tetanus (DPT,DT,TT) Shot MUST be listed here _____

Has the camper ever had or now have any of the following medical problems?

- Asthma Frequent ear Infections/cold /sore throats Chicken Pox HIV TB Diabetes
Bleeding/Clotting Disorder Convulsions/Seizures Heart Disease or Defect Hypertension Kidney Disease
Behavioral/Emotional Problems Sickle Cell Disease Other: Please explain : _____

Please check the following conditions that apply to the camper:

- Athlete's Foot/Ringworm Bed Wetting Sleepwalking Special Diet Fainting Motion Sickness
Hearing Impairment Ear Tubes Wears Glasses/Contacts Menstrual Cramps Stomach Upsets
Homesickness Nosebleeds Constipation Other Please explain : _____

Does the camper have any of the following allergies? (Please check and describe)

ALLERGIES: Describe Treatment

- Medications _____
Seasonal/Environmental _____
Insect Stings _____
Other _____

FOR CAMP USE ONLY: ON-SITE HEALTH EXAMINATION
General Health Condition:
Illnesses experienced or exposed to during preceding 30 days: _____
Recommendations and restrictions (activity, diet, etc): _____
Skin Lesions/Bruising: _____ Other _____
Signature of Examiner _____ Date _____