Health History for Camp OFLA

Camp OFLA

Camper

Name_____ Birth date_____ Age at camp
Last First Middle

Home address_____
Street address City State Zip

Gender: ☐ Male ☐ Female

Custodial parent/guardian with legal custody to be contacted in case of illness or injury:

Name:_____

Relationship to Camper: _____

Preferred Phone(s): (_____) _____ - _____ (_____) _____ - _____

Home address_____
(If different than above) Street address City State Zip

Email address _____

Second parent or guardian or emergency contact:

Name_____

Relationship to Camper: _____

Preferred Phone(s): (_____) _____ - _____ (_____) _____ - _____

Home address_____
(If different than above) Street address City State Zip

In an emergency, *if parents/guardians are not available*, notify:

Name_____

Relationship_____ Preferred Phone_____

Address_____
Street address City State Zip

Insurance Information:

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, indicate Insurance Company_____ Policy #_____

→ **Photocopy of front and back of health insurance card must be attached to this form.** ☐

Staff: Check and initial

Name of family physician_____ Phone_____

Name of family dentist/orthodontist_____ Phone_____

Name of medical specialist_____ Phone_____

IMPORTANT - This box MUST be signed for attendance***

Authorization for Treatment

The information on this form is correct and complete so far as I know. The person described herein (**"camper"**) has permission to participate in all camp activities except those noted. I hereby give permission to Outdoor Ministries to transport the **camper** named on this form to an Emergency Room, and in the same event I also give permission to the physician selected or assigned to order X-rays, routine tests, treatment related to the health of the **camper** for both routine health care and in emergency situations. If I cannot be reached in an emergency, or if I am the **camper** and my emergency contact cannot be reached, I give my permission to the physician for any of the following actions as it pertains to the **camper** named above: hospitalization, securing proper treatment, or ordering injection, anesthesia or surgery. (Note: If the **camper** is not of the age of majority, parents will be contacted if the **camper** has an illness or accident that is of concern to the Health Caregiver and Camp Manager. Parents will be contacted/consulted in the event that a trip to Urgent Care, Emergency Room or other off-site medical attention is necessary. In the event that the parents cannot be reached, the Health Caregiver or Camp Manager will try to reach an Emergency Contact Person listed above.) I understand the information on this form will be shared on a "need to know" basis with camp staff. In addition the camp has permission to obtain a copy of the **camper's** health record from providers who treat the **camper** and these providers may talk with the program's staff about the **camper's** health status.

Signature of parent/guardian or adult camper/staff

*** **If for religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.**

Year

Cabin or Group

Name

Name_____Birth date_____
Last First Middle

Health History

The following must be filled in by the parent/guardian, or adult camper or staff member. The intent of this information is to provide camp healthcare personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide completed information so that the camp can be aware of your needs.

Allergies	□ No known allergies □ This camper is allergic to: □ Food □ Medicine □ The environment (insect stings, hay fever, etc.) *Please describe below what the camper is allergic to and the reaction seen*
Dietary	□ This camper eats a regular diet □ This camper eats a regular vegetarian diet □ This camper eats a vegan diet □ This camper has special food needs. (*Please describe below)*
Restrictions	□ I feel the camper can participate without restrictions □ I feel the camper can participate with the following restrictions or adaptations. (*Please describe below)*
Medical History	please describe previous medical history including asthma, seizures, heart conditions, allergic reactions, etc

Medications

Please list ALL medications (including over-the counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. **Keep it in the original packaging/bottle** that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

□ This camper will not take any daily medications while attending camp
□ This camper will take the following daily medications while at camp *(Complete the chart below – attach additional page if necessary)*

Medication	Amount/ dose given	Route given	When it is given	Date started	Reason for taking it
			□ Breakfast □ Lunch □ Dinner □ Bedtime □ Other time:		
			□ Breakfast □ Lunch □ Dinner □ Bedtime □ Other time:		
			□ Breakfast □ Lunch □ Dinner □ Bedtime □ Other time:		

Identify any medications taken during the school year that camper may not or does not take during the summer.

Over the Counter Medications

The following non-prescription medications are stocked in Junior and Adult forms by the camp and are used on an as needed basis to manage illness and injury. **Cross out those that the camper should not be given.**

Acetaminophen (Tylenol)
Antihistamine/allergy medicine (Benadryl and Claritin)
Calamine lotion
Hydrocortisone cream Triple
antibiotic ointment
Ibuprofen (Advil, Motrin)
Generic cough drops / Throat Spray
Laxative (Ex-Lax)
Calcium carbonate (Tums)

Name_____Birth date_____
Last First Middle

IMMUNIZATIONS	HEALTH HISTORY
I attest that my child has received all required immunizations needed by school, and they are all up to date. If they are not, I understand and accept the risks to my child from not being fully immunized. Parent/Guardian:_____	**Check** if camper has: □ Sleep walking concern □ Epilepsy □ Bedwetting concern □ Seizures □ Bleeding/Clotting Disorder □ Diabetes □ Asthma Inhaler Sent? Yes □ No □ □ Severe allergic reaction Epi-Pen Sent? Yes □ No □
Please indicate the **date** of your campers most recent Tetanus Booster: Date _____ Not Sure □	Additional explanation of above if necessary
Please tell us of any current physical, mental, or psychological conditions that would require restrictions or special attention to any activities while at camp	

Can the camper swim? Yes No

Camp OFLA highly recommends that a camper receive a medical evaluation before attending camp.

Health Care Recommendations by Licensed Medical Personnel

I examined this individual on_____. A new exam is not necessarily required for camp attendance.

BP		Weight		Height	

In my opinion the above applicant □ **is** □ **is not** able to participate in an active camp program.
The applicant is under the care of a physician for the following conditions:

Recommendations and Restrictions at Camp

Treatment/Medications to be continued at Camp (name, dosage, frequency):

Any medically-prescribed meal plan or dietary restrictions:

Description of any limitation or restriction on camp activities:

Additional information for health care staff at the camp:

Signature of Licensed Medical Personnel: Printed Title Address

Phone Date

For Camp Use Only

Any signs/symptoms of illness (incl. COVID) or injury upon arrival?	□ Yes	□ No
Any signs/symptoms of head lice?	□ Yes	□ No
History of exposure to communicable disease?	□ Yes	□ No
Additions or corrections to information on this health history?	□ Yes	□ No
Medication given to healthcare staff?	□ Yes	□ No

Initial screening by_____Date_____Time:_____am / pm Screening has been conducted according to camp protocol (incl. COVID) and significant findings noted as follows:

Notes: Temperature:_____

Participant Agreement

Outdoor Ministries has informed me that this program is not without risks. Certain risks are inherent in outdoor programs and cannot be eliminated. The PHOC program and Camp OFLA can be quite active, mainly taking place out of doors, and due to the setting and activities some risk is involved. Although it is impossible to foresee all risks, some risks include tripping, falling, sunburn, hot/cold temperature extremes, poison ivy, fire-centered activities, low ropes initiatives, scrapes, bruises, bites, stings, blisters, and getting lost and exposure to COVID. The camp facility has bodies of water on it to include lakes, ponds, and streams and, although participants are not allowed near them without supervision, the water's presence does present the risk of drowning. Motor vehicle accidents may occur in the course of transporting camp participants to/from other locations or in an emergency. The participation of the person described herein (**"camper"**) is completely voluntary, and I agree for the **camper** to participate in spite of the risks. I agree to assume responsibility for the risks identified herein and those risks not specifically identified.

I agree that the **camper** is fully capable of participating in this program. Therefore, I assume and accept full responsibility for the **camper's** bodily injury, death, loss of personal property, and also loss or damage to any camp property and any expenses as a result of those inherent risks identified herein and those inherent risks not specifically identified, and as a result of the **camper's** participation in this program. I understand and am aware that participation in the PHOC Outdoor program and Camp OFLA by the **camper** will include many physical activities and the potential for accidents does exist. I agree that my private health insurance will be utilized as the primary health insurance coverage in the event of an accidental injury. I understand the possible risks associated with an outdoor program, assume these risks for the **camper** and hold blameless Camp OFLA, any affiliated persons or entities, and all of its employees and associates. I further agree that should the **camper** become ill or injured or demonstrate, in the judgment of PHOC or Camp OFLA, repeated or severely inappropriate or unsafe behavior, I, or someone representing me, will remove and transport the **camper** home.

Camp OFLA has my permission to use any pictures or videos that include the **camper** participating in the program, or any written materials that the **camper** writes about the program, for promotional purposes including use in online social media or websites. If we do NOT have your permission to use the above mentioned items in the manner described, please initial here:_____

I have carefully read and clearly understand what is written above. I accept the terms and conditions stated herein and acknowledge that this agreement shall be effective and binding upon all heirs, assigns, personal representative estate, and myself and for all members of my family, including minor children.

_____ _____

Printed name of camper Printed name of parent/guardian (if applicable)

SIGN HERE _____ SIGN HERE _____

Signature of camper Signature of parent/guardian (if applicable)

Date of Signatures _____