Camper Medical Information and Authorization Form

Dakotas-Minnesota Area

United Methodist Camp & Retreat Ministry

Please bring this completed form to camper check-in, or complete form online at least 2 week prior to camp.

This form is **MANDATORY** and must be completed by the legal guardian of any participant, as well as all adult staff and volunteers, attending camping events. This form is **REQUIRED** at the time of camper check-in and the "Authorization Information" section (back page) **MUST** be signed.

Camp Session _____ **Camp Number**_____

General Information	**Camper Information:**	Name (last, first, middle):	
		Birth Date:	Grade Completed:
		Gender: ☐ Male ☐ Female	
		Home Address:	
	Parent/Guardian #1 with legal custody to be contacted in case of illness or injury:	Name:	Relationship to camper:
		Home Address (if different from above):	
		Preferred Phones: ( )	( )
		Email address:	
	Parent/Guardian #2 or other emergency contact: (not required)	Name:	Relationship to camper:
		Home Address (if different from above):	
		Preferred Phones: ( )	( )
		Email address:	
	Emergency Contact in event parent(s) or guardian(s) cannot be reached: **REQUIRED**	Name:	Relationship to camper:
		Preferred Phones: ( )	( )
		Email address:	

Insurance Information	Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No
	If so, indicate carrier or plan name:
	Policy or Group #:
	Policy holder name:

Allergy Information	☐ **No known allergies**	
	The camper is allergic to:	Please describe what the camper is allergic to, the reaction seen, and how it is treated:
	☐ Food(s)	
	☐ Medicine(s)	
	☐ The environment (insects, hay fever, etc.)	
	☐ Other	

Diet/ Nutrition	☐ **This camper eats a regular diet**
	☐ This camper has special dietary restrictions or modifications (Please describe):

Medication Information (Use additional pages as necessary)

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. All medications are collected, stored, and distributed by camp health care personnel. Please list **ALL** medications (including over-the-counter or non-prescription drugs) taken routinely.
Bring only enough medications 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 medication(s) while at camp:

Name of Medication:	Reason for taking:	Times Given:	Amount/Dose Given:	How dose is given:	Pill Count:		Initials: *(guardian and staff)*
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other:			In:		
Original Start Date: (mm/yyyy):					Out:		
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other:			In:		
Original Start Date: (mm/yyyy):					Out:		
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other:			In:		
Original Start Date: (mm/yyyy):					Out:		
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other:			In:		
Original Start Date: (mm/yyyy):					Out:		
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other:			In:		
Original Start Date: (mm/yyyy):					Out:		

Staff / Volunteers Only – Do you require any medication that might impair your ability to perform the essential functions of your position? ☐ **Yes** ☐ **No**

Medication Treatment Information

Non-prescription medications are stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. **DO NOT SEND OVER THE COUNTER MEDICATIONS WITH YOUR CAMPER.**

☐ Camp staff **has permission** to administer **over-the-counter** medications as necessary.

☐ Camp staff has permission to administer **over-the-counter** medications as necessary, **except the following**:

☐ Camper **should not be given** any **over-the-counter** medications.

Healthcare Providers

Name of Camper's Healthcare Providers	Phone:
Primary doctor(s):	( )
Dentist:	( )
Orthodontist:	( )

General Questions

Has/does the camper:	YES	NO	Has/does the camper:	YES	NO
1. Ever been hospitalized?			10. Had fainting or dizziness?		
2. Ever had surgery?			11. Passed out or had chest pain during exercise?		
3. Have recurrent/chronic illnesses? (e.g., diabetes)			12. Had mononucleosis (mono) during the past 12 months?		
4. Had a recent infectious disease (e.g., flu)?			13. If female, have problems with periods/menstruation?		
5. Had a recent injury?			14. Have problems falling asleep, sleepwalking, or nightmares?		
6. Had asthma, wheezing, or shortness of breath?			15. Have a history of bedwetting?		
7. Had back or join problems?			16. Problems with diarrhea or constipation?		
8. Had seizures, headaches, or other neurological issues?			17. Have any skin problems?		
9. Wear glasses, contacts, or protective eyewear?			18. Traveled outside the country in the past 9 months?		

Please explain "YES" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

Mental, Emotional And Social Health

Has the camper:	Yes	No
Ever been **diagnosed with** attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD)?		
Ever been **diagnosed with** emotional or behavioral difficulties, or an eating disorder?		
During the past 12 months, seen a professional to address mental/emotional health concerns?		
Had a significant life event that continues to affect the camper's life? *(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)*		

Please explain "Yes" answers in the space below, attaching a separate sheet if more space is needed. The camp may contact you for additional information.

Immunization, Disease, and Exam History

	Yes	No
Are the camper's immunizations/vaccinations up to date according to state school standards? If no, please explain:		
Has the camper had a positive TB Mantoux test? If yes, date: _____		
Date of last Tetanus shot:		
Date of last Health Exam:		

Restriction Information	
	☐ **I have reviewed the program/activities of the camp and feel that the camper can participate without restrictions**
	☐ I have reviewed the program/activities of the camp and feel that the camper may require activity restrictions (to be discussed with the camp nursing staff) *Please describe restrictions:*

Additional Information	
	YOU WILL BE CONTACTED IF: • Your camper is exposed to a communicable disease • Outside medical attention is necessary (e.g., if we transport your camper to a hospital/Dr. office) • Your camper is having discipline problems that jeopardize the safety of others
	WHAT HAVE WE FORGOTTEN TO ASK? ***Please provide in the space below*** *any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. Attach additional information if needed.*

Authorization Information		
	PARENT/GUARDIAN AUTHORIZATION FOR HEALTH CARE This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status. I understand that camp insurance is a supplemental policy only. It will pay whatever my own insurance doesn't cover (deductible or over) up to the limit of the policy. If medical (sickness, injury) care is needed, billings will be sent to the parent/guardian who will be responsible for direct payments to physician, hospital, clinic, etc.	
	Signature of Custodial Parent/Guardian:	**Date:**
	My Camper will be riding home with :	Phone:

Staff Use Only		Yes	No		Yes	No
	Recent exposure to communicable disease, illness, injury?			Any allergies?		
	Authorization section signed?			Meds checked in , pill counts documented?		
	Anything that requires follow-up?			All info current and complete?		
	Staff Initials:			Date:		