

# CAMPER HEALTH HISTORY FORM - PAGE 1

Please Print All Information

Winter: see your youth leader  
 Summer: send the forms to the address below at least two weeks prior to start of camp

**Monadnock Bible Conference**  
 PO Box 70  
 Jaffrey, NH 03452

**Questions?**  
 Call  
 Sue Williams  
 603-532-8321

Dates will attend camp: \_\_\_\_\_ to \_\_\_\_\_ Church/Group: \_\_\_\_\_  
Month/Day/Year                      Month/Day/Year

Camper Name: \_\_\_\_\_  
First Name                      Middle                      Last

M  F      Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age on arrival at camp \_\_\_\_\_  
Month      Day      Year

**To Parents(s)/Guardian(s): Please follow the instructions below.**  
 Attach additional information if needed.

1. Complete pages 1, 2, and 3 of this form and keep a copy at home.
2. For Winter camps (weekend events), turn in signed forms PAGES 1, 2, & 3 to your youth leader.
3. For Summer Camps (a physical exam is required within 24 months):
  - a. Complete the top of PAGE 4 (CAMPER MEDICAL EVALUATION) and provide the copy of PAGES 1, 2, & 3 with PAGE 4 to your child's health-care provider for review and completion.
  - b. After PAGE 4 has been completed and signed by your child's health care provider, keep a copy at home and return all PAGES 1, 2, 3, & 4 to camp at least 2 weeks before arrival for camp.

Camper Home Address: \_\_\_\_\_  
Street Address                      City                      State                      Zip Code

**Parent/guardian with legal custody to be contacted in case of illness or injury:**

Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_ Preferred Phones (\_\_\_\_) \_\_\_\_\_  
 Email \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Home Address (If different from above) \_\_\_\_\_  
Street Address                      City                      State                      Zip Code

**Second parent/guardian or other emergency contact:**

Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_ Preferred Phones (\_\_\_\_) \_\_\_\_\_  
 Email \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

**Additional contact in event parent(s)/guardian(s) cannot be reached:**

Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_ Preferred Phones (\_\_\_\_) \_\_\_\_\_  
 Email \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

**Allergies:**  No known allergies  This camper is allergic to  Food  Medicine  The environment (insect stings, hay fever, etc.)  Other  
 (Please describe what the camper is allergic to and the reaction seen)

**Diet, Nutrition:**  This camper eats a regular diet  This camper eats a regular vegetarian diet.  
 This camper has special food needs (Please describe - attach additional information if necessary)

**Restrictions:**  I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.  
 I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. (Please describe)

**Medical Insurance Information:**

This camper is covered by family medical/hospital insurance  Yes  No  
 Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Insurance Company Phone Number: (\_\_\_\_) \_\_\_\_\_

**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 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. Signature of parent or guardian is required for camp attendance.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Custodial Parent/Guardian                      Date                      Relationship to Camper

**CAMPER HEALTH HISTORY FORM PAGE 2**

Camper Name \_\_\_\_\_

Birth Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

**Immunization History:** Provide the month & year for immunizations. Starred (\*) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, tetanus, pertussis * (DTaP) or Tdap)						
Tetanus booster * (dT) or (Tdap)						
Mumps, measles, rubella * (MMR)						
Polio * (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCB)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)	<input type="checkbox"/> Had chicken pox Date: _____					
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test      Date: \_\_\_\_\_       Negative       Positive

If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized. If my child is in a situation where he/she needs a Tetanus shot and I cannot be reached, I  will  will not allow the camp's medical provider to send my child to the camp's local Doctor for a Tetanus immunization.

Signature of Custodial Parent/Guardian \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      Date \_\_\_\_\_      Relationship to Camper \_\_\_\_\_

**Medication:**  This camper will not take any daily medications while attending camp.  
 This camper will take the following daily medication(s) while at camp.  
 "Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. Monadnock Bible Conference and NH State Law requires original pharmacy containers with labels, which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.

Name of Medication	Date Started?	Reason for Taking It	When it is given	Amount or dose given	How it is given
			Breakfast Lunch Dinner Bedtime Other time:		
			Breakfast Lunch Dinner Bedtime Other time:		
			Breakfast Lunch Dinner Bedtime Other time:		

If you need to write in other medications, please continue on the backside or another page.

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. Cross out those the camper should not be given.

- |   |   |
|---|---|
| Acetaminophen (Tylenol)                                   | Generic cough drops                                 |
| Aloe  | Hydrocortisone Cream                                |
| Antibiotic cream, topical                                 | Ibuprophen  |
| Antifungal spray/powder                                   | Lice shampoo or cream (Nix, Elimite, or mayonnaise) |
| Calamine lotion   | Pseudoephedrine decongestant (Sudafed)              |
| Cough syrup   | Saline eye drops (Visine or Clear Eyes)             |
| Diphenhydramine antihistamine/allergy medicine (Benadryl) | Sore throat gargle                                  |
| Electrolyte (drink/powder)                                | Tums  |
| Epinephrine (Epi-pen for severe allergic reactions)       |   |

**CAMPER HEALTH HISTORY FORM PAGE 3**

Camper Name \_\_\_\_\_

Birth Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

**General Health History:** Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does the camper:

- |  |        |  |        |
|--|--------|--|--------|
| 1. Ever been hospitalized? (date: _____)   | Yes No | 11. Had fainting or dizziness?                               | Yes No |
| 2. Ever had surgery? (date: _____)         | Yes No | 12. Passed out/had chest pain during exercise? (date: _____) | Yes No |
| 3. Have recurrent/chronic illnesses?       | Yes No | 13. Had mononucleosis "mono" in past 12 months?              | Yes No |
| 4. Had a recent infectious disease?        | Yes No | 14. If female, have problems with periods/menstruation?      | Yes No |
| 5. Had a recent injury? (date: _____)      | Yes No | 15. Have problems with falling asleep/sleepwalking?          | Yes No |
| 6. Had asthma/wheezing/short breath?       | Yes No | 16. Ever had back/joint problems?                            | Yes No |
| 7. Have diabetes?                          | Yes No | 17. Have a history of bedwetting?                            | Yes No |
| 8. Had seizures? (date most recent: _____) | Yes No | 18. Have problems with diarrhea/constipation?                | Yes No |
| 9. Had headaches?                          | Yes No | 19. Have any skin problems?                                  | Yes No |
| 10. Glasses, contacts, protective eyewear? | Yes No | 20. Traveled outside the country in the past 9 months?       | Yes No |

Country: \_\_\_\_\_ Dates: \_\_\_\_\_ to \_\_\_\_\_  
 Country: \_\_\_\_\_ Dates: \_\_\_\_\_ to \_\_\_\_\_

Please explain "Yes" answers in the space below, noting the number of the questions:

**Mental, Emotional, and Social Health:** Check "Yes" or "No" for each statement

- |   |        |
|---|--------|
| 1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder AD/HD?  | Yes No |
| 2. Ever been treated for emotional or behavioral difficulties or an eating disorder?  | Yes No |
| 3. During the past 12 months, seen a professional to address mental/emotional health concerns?  | Yes No |
| 4. Had a significant life event that continues to affect the camper's life?<br>(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others) | Yes No |

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

**Health Care Providers:**

Name of camper's primary doctor(s): \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Name of your dentist(s): \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Name of orthodontist(s): \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

**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.**