

CAMP WESTMINSTER HEALTH FORM
1438 Sheridan Road Atlanta, GA 30324 770-483-2225

Name _____ Sex _____

Address _____

Phone _____ Birthdate _____ SS# _____

Session(s): Session Name _____ Date _____

List all sessions Session Name _____ Date _____

camper is attdg. Session Name _____ Date _____

Session Name _____ Date _____

Session Name _____ Date _____

Custodial parent/guardian _____

Home address _____

(if different from above)

Business address _____

Home phone _____ Business phone _____

Second parent or guardian or emergency contact _____

Home address _____

Home phone _____ Business phone _____

In the event a child needs to see a physician, Camp Westminster cannot be responsible for transportation to & from the doctor. The custodial parent or guardian will be notified to come and transport the child, or in the case of an emergency, the child will be transported by EMT services. In this document, "Camp Westminster" means the sponsor of the activities in which the registrant engages on the campus known as Camp Westminster, whether Westminster Presbyterian Church or Camp Westminster, LLC. Also in this document, Camp Properties refers to the owner of any part of the campus on which the registrant engages in activities, whether Westminster Presbyterian Church or Christian Camp Properties, LLC.

IMPORTANT – THESE BOXES MUST BE COMPLETED FOR ATTENDANCE

Permission to Provide Necessary Treatment or Emergency Care: I hereby give permission to the medical personnel selected by the camp director or other person given such selection authority by Camp Westminster (hereinafter called "camp director") to order X-rays, routine tests, and treatment, to release any records necessary for insurance purposes, and to provide or arrange necessary related transportation, for me or my child. In the event my child or I experience a medical emergency, and camp personnel try but fail to reach me or under the circumstances are without sufficient time to try to reach me, I hereby give permission to the physician or other medical personnel selected by the camp director to secure and administer treatment, including hospitalization, anesthesia, surgery, and injections of medication for me or my child.

Signature of parent or guardian or adult camper/staff member _____

PLEASE SIGN _____ DATE _____

PLEASE PRINT _____

I understand and agree to abide by any restrictions placed on my camp activities.

SIGNATURE OF PARTICIPANT _____ DATE _____

INSURANCE INFORMATION

Is the participant covered by family medical/hospital insurance? _____

Indicate carrier or plan name _____ Group # _____

Name of insured _____ Relationship to participant _____

Social security number of policy holder or insurance ID number _____

Camp Westminster maintains for participants during their camping session(s) an insurance policy that works with your family insurance policy or program. Our insurance only complements your policy/program and may not provide complete coverage for your participant due to exclusions and limitations. For that reason it is imperative that you include your policy/program number and insurance company on this form.

HEALTH INFORMATION (Applicable to all campers and staff)

PLEASE NOTE: All accidents and illnesses must be reported to the camp nurse before the participant leaves camp. No insurance claims are allowed unless the nurse has been notified.

The participant is not allowed to possess any type of medicine on camp grounds unless he or she has a letter of explanation (signed by parent or physician) telling what the medication is and why the participant should have it. If any medicine is necessary, check here and attach explanatory letter.

Name of participant _____ Age _____

Family Doctor _____ Phone _____

FOR ALL STAFF MEMBERS: THIS INFORMATION MAY BE PROVIDED BY YOUR PARENT/GUARDIAN, DOCTOR, OR YOU (if you are 18 years of age or older).

FOR ALL CAMPERS: YOUR PARENT, GUARDIAN, OR YOUR DOCTOR MAY FURNISH THIS INFORMATION.

GENERAL HEALTH QUESTIONS: Has/does the participant:

- | | |
|--|--|
| <input type="checkbox"/> Have a chronic or recurring illness/condition? | <input type="checkbox"/> Ever been hospitalized? |
| <input type="checkbox"/> Had any recent injury, illness, or infection disease? | <input type="checkbox"/> Ever had surgery? |
| <input type="checkbox"/> Ever been knocked unconscious? | <input type="checkbox"/> Ever had seizures? |
| <input type="checkbox"/> Wear glasses, contacts, or protective eyewear? | <input type="checkbox"/> Ever had frequent ear infection? |
| <input type="checkbox"/> Ever passed out during or after exercise? | <input type="checkbox"/> Ever had high blood pressure? |
| <input type="checkbox"/> Ever been dizzy during or after exercise? | <input type="checkbox"/> Ever had back problems? |
| <input type="checkbox"/> Ever had chest pain during or after exercise? | <input type="checkbox"/> Have diabetes? |
| <input type="checkbox"/> Ever been diagnosed with a heart murmur? | <input type="checkbox"/> Have asthma? |
| <input type="checkbox"/> Ever had problems with joints (e.g., knees, ankles)? | <input type="checkbox"/> Have problems with sleepwalking? |
| <input type="checkbox"/> Had problems with diarrhea/constipation? | <input type="checkbox"/> Have a history of bed-wetting? |
| <input type="checkbox"/> Had mononucleosis in the past 12 months? | <input type="checkbox"/> Ever had an eating disorder? |
| <input type="checkbox"/> Have any skin problems (e.g., itching, rash, acne)? | <input type="checkbox"/> Ever had a head injury? |
| <input type="checkbox"/> If female, have an abnormal menstrual history? | <input type="checkbox"/> Have frequent headaches? |
| <input type="checkbox"/> Have an orthodontic appliance being brought to camp? | <input type="checkbox"/> Have sickle cell anemia or sickle cell trait? |
| <input type="checkbox"/> Ever had emotional difficulties for which professional help was sought? | <input type="checkbox"/> Had or been exposed to TB or chicken pox in the past month? |
| <input type="checkbox"/> Have allergies, including insect bites? | <input type="checkbox"/> Have any other medical conditions not covered above? (Please explain below) |
| <input type="checkbox"/> Had a reaction to a prescription drug? | |

Please explain all above checked items, and describe all other health conditions, injuries, prior events, and circumstances that may affect or be relevant to participation in camp activities or medical treatment; attach an extra sheet if necessary.

DISEASES: Check any of the following the participant has had:

- | | |
|--|---|
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Mumps Polio | <input type="checkbox"/> Other |
| <input type="checkbox"/> Rheumatic fever | _____ |

Details on any of the above _____

IMMUNIZATION RECORD – Give year of each inoculation, if known. If the participant has not been inoculated against the disease or condition, write “none” in the space.

_____ Diphtheria	_____ Smallpox	_____ Polio	_____ Tetanus	_____ Typhoid
_____ Rubella	_____ Tuberculosis Test	_____ Whooping cough	_____ Other	

PERMISSION TO TREAT

I, _____, hereby give permission for Camp Westminster to administer the following over-the-counter medications to me or my child _____ if the designated staff deems it necessary. Dosages will be administered according to the directions of the bottle unless a physician directs otherwise.

- | | |
|--|--|
| Athlete’s Foot/ Jock Itch.....Antifungal Sprays or Powders | Poison Ivy.....Calamine lotion, Benedryl, Hydrocortisone |
| HeadacheTylenol, Advil, Motrin | Mild allergic reactions.....Diphenhydramine |
| Upset Stomach.....PeptoBismol, Tums | Colds, congestion.....Pseudoephedrine |
| Diarrhea.....Immodium AD | Insect bites.....Lanacaine spray and/or Diphenhydramine |
| Menstrual cramps.....Ibuprophen | |

Signed _____ Date _____