CAMP WESTMINSTER HEALTH FORM

1438 Sheridan Road Atlanta, GA 30324 770-483-2225

Name _____ Sex _____

Address _____

City _____ State _____ Zip _____

Phone _____ Birthdate _____

Session(s) (*List all sessions camper is attdg.*):

Session Name _____ Date _____

Session Name _____ Date _____

Session Name _____ Date _____

Session Name _____ Date _____

Session Name _____ Date _____

Custodial parent/guardian _____

Home address _____

(if different from above)

Home phone _____ Cell phone _____

Second parent or guardian or emergency contact _____

Home address _____

(if different from above)

Home phone _____ Cell 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 Camp Westminster Foundation, Inc., 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 Camp Westminster Foundation, Inc., 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

_____

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? Yes No

Indicate carrier or plan name _____ Group # _____

Name of insured _____ Relationship to participant _____

Social security number of policy holder or insurance ID number _____

HEALTH INFORMATION

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 CAMPERS: YOUR PARENT, GUARDIAN, OR YOUR DOCTOR MUST FURNISH THIS INFORMATION.

GENERAL HEALTH QUESTIONS: Has/does the participant:

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

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:

- ❑ Chicken pox
- ❑ Measles
- ❑ Mumps Polio
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Whooping cough
- ❑ Other _____

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. (A copy of your most recent immunization record from your doctor may be attached)

_____ DTP, DTaP, DT _____ Td, TdaP _____ HepB _____ OPV _____ IPV

_____ Measles _____ Mumps _____ Rubella _____ HepA _____ Varicella

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
Headache .....Tylenol, Advil, Motrin
Upset Stomach .....PeptoBismol, Tums
Diarrhea.....Immodium AD
Menstrual cramps.....Ibuprophen
Poison Ivy .....Calamine lotion, Benedryl, Hydrocortisone
Mild allergic reactions.....Diphenhydramine
Colds, congestion .....Pseudoephedrine
Insect bites .....Lanacaine spray and/or Diphenhydramine

Signed_____ **Date**_____