

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 care 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 or Custodial Parent/Guardian Date Relationship to Camper

CAMPER HEALTH HISTORY FORM PAGE 2

Camper Name _____

Birth Date _____
First Middle Last
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 or 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
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> 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, Elimate, 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 MEDICAL EVALUATION TO BE COMPLETED BY LICENSED MEDICAL PERSONNEL - PAGE 4

Please Print All Information

*Return Completed Form by
Two weeks prior to camp event*

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

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

To **Parents(s)/Guardian(s)**: Complete this section and give **this form (page 4)** and a copy of your completed CAMPER HEALTH HISTORY FORMS (pages 1,2, & 3) to your child's health-care provider for review.

Dates will attend camp: ____/____/____ to ____/____/____
Month Day Year Month Day Year

Camper Name: _____
First Name Middle Last

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

Camper Home Address: _____

Street Address City State Zip Code

Custodial parent(s)/guardian(s) telephone: (____) _____

PARENT(S)/GUARDIAN(S) STOP HERE. REST OF THIS FORM TO BE COMPLETED BY MEDICAL PERSONNEL.

The following non-prescription medications are commonly stocked in our camp's Health Center and will be used on an as needed basis to manage illness and/or injury.
Medical personnel:
CROSS OUT those items the camper should not be given...

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

Monadnock Bible Conference and the State of NH policy require a physical exam within last 24 months.

Weight ____ lbs Height ____ft ____ in Blood Pressure ____ / ____

Allergies: (list with reactions)

- No known allergies
- Food:
- Medicine:
- The environment (insect stings, hay fever, etc.):
- Other (*list all*):

Diet, Nutrition: This camper eats a regular diet Has a medically prescribed meal plan or dietary restrictions: (describe below)

This camper is undergoing treatment at this time for the following conditions: (describe below). None

Medication: No daily medications Will take the following prescribed daily medication(s) while at camp. (name, dose, frequency - describe below)

Other treatments/therapies to be continued at camp: (describe below) None needed

Do you feel that the camper will require limitations or restrictions to activity while at camp? No Yes
If you answered "Yes" to the question above, what do you recommend? (describe below - attach additional information if needed)

"I have reviewed the CAMPER HEALTH HISTORY FORMS (pages 1, 2, & 3), and discussed the camp program with the parent(s)/guardian(s). It is my opinion the camper is physically and emotionally fit to participate in an active camp program (except as noted above).

Name of licensed provider w/title (please print): _____ Signature _____ Date _____
Office Address _____
Street Address City State Zip Code
Telephone (____) _____ **Date of camper's physical exam: ____/____/____**