

Cabin _____
 (Completed by staff)

CAMP CALVIN HEALTH AND AUTHORIZATION FORM - 2011

Parents, complete this form and give to your **church's contact person** no later than May 20.

Camper Name: _____		Sex: M / F	Race: _____
Age: _____	Date of Birth: _____	Church: _____	
Home Address: _____		City: _____	State: _____ Zip: _____
Parent/Guardian: _____		Phone: () _____	
Emergency Contact Person: (other than parent/guardian)		Phone: () _____	
Emergency Contact Person's Address: _____			

Health Insurance: Yes No Policy in name of: _____

Insurance Company: _____ Insurance Policy Number: _____

Do you have any health concerns for the camper while at camp? YES NO (please explain)

Will the camper require any dietary modifications while at camp? If yes, please explain: _____

Is the camper taking any prescription or over the counter medication **on a daily basis**? Please list in the table below.

Does Camp Calvin have your permission to give the camper common over the counter medications, such as acetaminophen (Tylenol), ibuprophen (Advil), or diphenhydramine (Benadryl)? YES NO If no, please explain: _____

The camp nurse has **these** common over the counter medications. **Please do not send these to camp. For safety reasons and by state regulation, campers may not keep any medications and everything the camper brings must be inventoried by the camp nurse.**

All prescription medications, including sprays and inhalers, must be in either a prescription bottle/box, labeled exactly as it is to be given, or accompanied by a written physician prescription form. Do not bring *occasionally used* over the counter medications.

<i>Medications Needed or Used:</i>	<i>Frequency & Times</i>	<i>Dosage</i>

IMPORTANT: Please notify the camp if this camper is exposed to any communicable disease during three weeks prior to camp attendance.

HEALTH HISTORY		Approx. Dates
Frequent Ear Infections	Y / N	
Heart Defect/Disease	Y / N	
Convulsions	Y / N	
Diabetes	Y / N	
Bleeding/Clotting Disorders	Y / N	
Hypertension	Y / N	
Mononucleosis	Y / N	
Chicken Pox	Y / N	
Measles	Y / N	
German Measles	Y / N	
Mumps	Y / N	
ALLERGIES		Date of Last Reaction
Ivy Poisoning, etc.	Y / N	
Insect Sting	Y / N	
Penicillin, or other drugs	Y / N	
Hay Fever	Y / N	
Asthma	Y / N	
Other	Y / N	

Operations or serious injuries (include dates):

Disability of chronic or recurring illness:

Are there any other special conditions such as bed-wetting, fainting, sleep walking, etc. which the camp staff should be aware of?
If yes, please explain:

Date of last tetanus immunization: _____

Name of Dentist/Orthodontist:	Phone: ()
Name of Family Physician:	Phone: ()

PARENT'S AUTHORIZATION: This health report is correct as far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me. In the event I cannot be reached in an **emergency**, I hereby give my permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child as named above.

HOLD HARMLESS AGREEMENT:
Camp Calvin is a Christian Camp held for our children. Many activities occur and are all under the supervision of our volunteer staff plus Camp Whitcomb staff. As with all camps, however, injury and/or illness can occur.

I, as a parent or guardian, assume all liability for the action and conduct of my child during Camp Calvin. I agree to release Camp Calvin and staff and Camp Whitcomb and staff from all liability in the event of an injury or illness.

SIGNATURE OF PARENT OR GUARDIAN _____ **Date** _____