

**CAMP CALVIN HEALTH AND AUTHORIZATION FORM - 2008**Parents, complete this form and give to your **church's contact person** no later than May 20.

Camper Name:				Sex: M / F	
Age:	Date of Birth:	Church:			
Home Address:	City:	State:	Zip:	Phone: (     )	
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: \_\_\_\_\_

Should camper's activities be restricted because of any physical/medical reason?  YES  NO (please explain)

Will the camper require any dietary modifications? If yes, please explain: \_\_\_\_\_

Special Medication:  YES  NO Are you bringing it?  YES  NO **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 over the counter medications.**

Medications Needed or Used:	Frequency & Times	Dosage	Currently Being Given?

**PHYSICIAN'S APPRAISAL: To be filled out by a licensed physician or registered nurse (Physical valid for 2 years)**

HGT. \_\_\_\_\_ WT. \_\_\_\_\_ B.P. \_\_\_\_\_ HEART \_\_\_\_\_

SKIN \_\_\_\_\_ EARS \_\_\_\_\_ EYES \_\_\_\_\_ GLASSES \_\_\_\_\_

NOSE \_\_\_\_\_ TEETH \_\_\_\_\_ THROAT \_\_\_\_\_ LUNGS \_\_\_\_\_

ABDOMEN \_\_\_\_\_ HERNIA \_\_\_\_\_ GENITALIA \_\_\_\_\_

SPINE \_\_\_\_\_ FEET \_\_\_\_\_ EXTREMITIES \_\_\_\_\_

REMARKS (Especially any restrictions on any activities) \_\_\_\_\_

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in all camp activities, except as noted above.

\_\_\_\_\_  
Examining Physician or Nurse\_\_\_\_\_  
Address\_\_\_\_\_  
Date of Examination\_\_\_\_\_  
Phone

**IMMUNIZATION HISTORY – Dates must be provided for campers to be admitted.**

List the MONTH, DAY AND YEAR your child received each of the following immunizations. DO NOT USE A (✓) or (X) except to answer the question about chickenpox. If you do not have an immunization record for this student at home, contact your doctor or public health agency to obtain the dates.

TYPE OF VACCINE*		FIRST DOSE mo/day/yr	SECOND DOSE mo/day/yr	THIRD DOSE mo/day/yr	FOURTH DOSE** mo/day/yr	FIFTH DOSE mo/day/yr
DTaP/DTP/DT/Td (Diphtheria, Tetanus, Pertussis)						
Polio						
Hepatitis B	3 dose pediatric formulation				*Hib vaccine is only required for children in licensed day care centers. Do <u>not</u> report the dates your child received Hib vaccine on this form.	
	2 dose adolescent formulation					
MMR (Measles, Mumps, Rubella)						
Varicella (Chickenpox) Note: Vaccine is required only if your child has not had chickenpox disease. See below:						
Has your child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known: YES _____ year (Vaccine not required) NO or Unsure (Vaccine required)						

**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:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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** \_\_\_\_\_