



CAMPER HEALTH HISTORY FORM

Please Attach a Photo of Camper to this form.

STEP #1: CAMPER INFORMATION

Camper's Name: _____ D.O.B: ____ / ____ / ____ Gender: _____
 Home Address: _____
 City, County, State, Zip: _____
 Home Phone #: _____ Social Security Number: _____
 Physician's Name: _____ Physician's Phone #: _____
 Preferred Health Care Facility: _____
 Parent/Guardian Information:
 Mother's Name: _____
 Mother's Work #: _____ Mother's Cell #: _____
 Father's Name: _____
 Father's Work #: _____ Father's Cell #: _____

STEP #2: INSURANCE INFORMATION

ALL PARTICIPANTS MUST BE COVERED BY HEALTH INSURANCE

Health Insurance Carrier: _____
 Policy#: _____ Group #: _____

**A COPY OF THE FRONT AND BACK OF THE INSURANCE CARD
MUST BE ATTACHED TO THIS FORM!**

STEP #3: PARENT/GUARDIAN PERMISSION TO TREAT AGREEMENT

This Medical Release Statement states the risks of illness, injury, harm, and medical procedures at PARADISE FARM CAMPS. It has important legal consequences. You should decide to send your child to camp only after you have read and understood the Medical Release Statement and decided that you wish you and your child to be bound by its terms. For your convenience, you (or each of you) is referred to in the Agreement as "I" and your child is referred to as "my camper" and the Children's Country Week Association and all of its officers, directors, employees and agents are referred to together as the "Association."

I am the parent or legal guardian of _____ (Camper's Name). I understand that camping has many risks. It involves such things as vigorous physical activity, the close gathering of large groups of people, communal living arrangements, and a rural outdoor setting. Participation in camp activities may entail exposure to serious risks posed by the natural and/or outdoor environment, such as tick borne diseases including Lyme Disease and Rocky Mountain Spotted Fever, Poison Ivy, etc.

If my camper becomes ill or is injured while at camp; I understand that my camper will first be evaluated by the Camp Health Service Provider or a Physician selected by the Association, and I authorize him or her to make all inquires, examinations and tests he or she deems necessary or appropriate. If he or she determines that it is appropriate to administer treatment at the Camp, I authorize that treatment. I release the Association from all liability which may result from the evaluation and treatment of my camper by the Camp Health Service Provider or that Physician.

If the Camp Health Service Provider of that Physician determines that other treatment is necessary or appropriate, I want the Association to try to reach me or those emergency contacts designated in the registration form in the order listed.

If reached, I will tell you whether and by whom I wish my camper to be treated. In an emergency, or if I cannot be reached in a timely fashion, I authorize the Association to deliver my camper to a Health Care Provider selected by the Association, for such treatment as that Provider considers appropriate. I agree that the Association shall not be responsible for what happens after my camper has been returned to me or delivered to a Health Care Provider so chosen by me or the Association, and I release it from all liability therefore. I agree that I am responsible for the cost of any outside health care provided and the cost of transporting my camper.

The undersigned agrees to be bound by and to have the undersigned's camper be bound by this agreement.

Camper's Parent or Guardian Signature

Date Signed

STEP #4: MEDICAL HISTORY - TO BE FILLED OUT BY PARENT OR GUARDIAN

PAST OR CURRENT HISTORY: Please check all that apply

- | | |
|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gastrointestinal problems |
| <input type="checkbox"/> Chronic, Recent or Recurring Illness | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cardiovascular Disorders | <input type="checkbox"/> Emotional or Behavioral Difficulties |
| <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> Developmental Problems |
| <input type="checkbox"/> Bed Wetting (Resident Camp only) | <input type="checkbox"/> Other Medical Concerns |

Attach a separate sheet if necessary.

Please describe any current or past physical, mental or psychological problems: _____

Has your child ever been on a medication for behavior or emotional problems? If so, is he/she still on medication? Please explain: _____

Has the child ever been hospitalized for a mental or emotional problem? If so, please explain when, for how long, and what was the diagnosis? _____

ALLERGIES (include food, drugs, bee stings, etc): _____

DIETARY RESTRICTIONS (vegetarian, religious, etc): _____

Description of any past medical treatment, if any: _____

Description of any camp activities from which the camper should be exempted for health reasons: _____

STEP #5: IMMUNIZATIONS AND MEDICATION

Immunization/Disease History: Please fill out the following section or attach the necessary information.

Which of the following has the participant had?

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

Tuberculosis Test (PPD)

Date of last test: _____

Result: Positive Negative

Please give all the dates of immunizations for: Mo/Yr Mo/Yr Mo/Yr Mo/Yr Mo/Yr Mo/Yr

DTP	_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____	_____
or Mumps	_____	_____	_____	_____	_____	_____
or Measles	_____	_____	_____	_____	_____	_____
or Rubella	_____	_____	_____	_____	_____	_____
Haemophilus influenza B	_____	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	_____	_____
Varicella (Chicken Pox)	_____	_____	_____	_____	_____	_____

MEDICATIONS: Please list ALL current medications including prescribed and over-the-counter drugs taken.

Attach a separate sheet if necessary.

Med #1: _____ Dosage: _____ Time taken each day: _____ Reason: _____

Med #2: _____ Dosage: _____ Time taken each day: _____ Reason: _____

Med #3: _____ Dosage: _____ Time taken each day: _____ Reason: _____

ALL CAMPERS MUST HAVE A CURRENT CAMPER HEALTH HISTORY FORM RETURNED TO THE CAMP OFFICE BY MAY 21ST. ANY CAMPER WITHOUT A CURRENT CAMPER HEALTH HISTORY FORM BY MAY 21ST MAY HAVE THEIR REGISTRATION REMOVED.

ANY QUESTIONS OR CONCERNS PLEASE CONTACT CAMP DIRECTOR, RICK KONE

610-269-9111 X. 210