



Summer 2010 Health History Form

BRING THIS FORM TO CAMP. DO NOT MAIL IT AHEAD OF TIME.

Name of Camper _____

Site _____ Program _____

(NOTE: If camper is attending more than 1 program, a separate Health History form is needed for each program.)

Birthdate _____ Grade Completed _____ Male Female

Address _____ City, State & Zip _____

Home Phone _____ Church, City _____

Parent/Guardian(s) _____

Work Phone(s) (include name & number) _____

Cell Phone(s) (include name & number) _____

Church, City _____

If parent/guardian is not available at above numbers, emergency contact is...

Name & Relationship _____ Phone _____

HEALTH INSURANCE

Please attach a copy of your insurance card (both sides) to this form.

Insurance Company _____ Policy No _____ Phone _____

Health Care Provider's Name _____ Phone _____

Address _____

Crossways carries SECONDARY insurance only. You are responsible for all PRIMARY coverage.

HEALTH HISTORY (To be completed by parent or guardian.)

1. Check if camper has been subject to medical treatment for any of the following:

Diabetes _____

Allergies _____

Asthma _____

Please explain above: _____

2. Give dates of immunizations: Tetanus DPT _____ Polio _____ Mumps _____ Measles _____

3. Current medications: Give name, dose, schedule (medication MUST be brought in ORIGINAL labeled prescription bottle). _____

4. Please explain conditions requiring medication or other conditions requiring special care: _____

5. For female campers: Does camper know about menstruation? Yes No Has she menstruated? Yes No

If yes, is menstrual history normal? yes no If no, please give detail on measures used for comfort: _____

Does she use: Pads Tampons Both _____

----OVER----

Wisconsin State Health Code requires that this form (*completed and signed*) be on file at the camp in order for the camper to attend a residential Crossways Camping Ministries program.



BRING THIS FORM TO CAMP. DO NOT MAIL IT AHEAD OF TIME.

Name of Camper _____

6. **Over the Counter Medication:** The following are medications that we keep on hand at camp. Do not bring any of the medications listed below with you. Please place a check by all of the medications that you are comfortable with us giving your child. All medications are given according to instructions found on the medication packaging and per consulting physician's protocol.

- | | | |
|---|---|---|
| <input type="checkbox"/> Tylenol (children's) | <input type="checkbox"/> Actifed | <input type="checkbox"/> Imodium AD |
| <input type="checkbox"/> Tylenol (junior) | <input type="checkbox"/> Sudafed (Decongestant) | <input type="checkbox"/> Pepto Bismol/Mylanta |
| <input type="checkbox"/> Tylenol (adult) | <input type="checkbox"/> Benadryl Capsules | <input type="checkbox"/> Benadryl Cream |
| <input type="checkbox"/> Ibuprofen (Advil) | <input type="checkbox"/> Cough syrup/spray | <input type="checkbox"/> Eye Drops (Visine) |
| <input type="checkbox"/> Naproxen (Aleve) | <input type="checkbox"/> Cough drops | <input type="checkbox"/> Swimmer's ear drops |
| <input type="checkbox"/> Rid X (for lice) | | |

7. Check if camper is allergic to the following, please describe reaction and treatment needed:

- Penicillin _____
- Other Drugs _____
- Bee Stings _____
- Foods _____
- Other _____

8. Is the camper subject to homesickness? If yes, provide suggestions on how to handle circumstances: _____

9. List any special dietary **needs**, not preferences: (If your camper has a serious allergy or dietary restrictions please call the camp office at least two weeks in advance) _____

10. Please indicate any restrictions on physical activities or any concerns you may have regarding your child's stay at camp: _____

PARENTAL AUTHORIZATION – MUST BE SIGNED BY PARENT/GUARDIAN FOR ALL CAMPERS UNDER THE AGE OF 18!

My child has permission to take part in all camp activities, including offsite activities under supervision, and I agree that the camp, or its personnel, will not be held responsible for accidents or personal injury arising therefrom. In the case of a medical emergency, I understand that every effort will be made to contact the parents or guardians of the camper. In the event I cannot be reached I hereby give permission to the medical examiner selected by the Crossways staff to hospitalize, to secure proper treatment for, to order an injection, anesthesia, or surgery for my child as named on this form. I understand that Crossways Camping Ministries does not provide medical insurance.

I further authorize Crossways Camping Ministries to use photos, videos or other likeness of my child for Crossways publicity with no identifying information posted. Please initial here if you **DO NOT** authorize this use: _____

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

Wisconsin State Health Code requires that this form (completed and signed) be on file at the camp in order for the camper to attend a residential Crossways Camping Ministries program.