

Welcome to

Word of Life Florida Youth Camp

Dear Parent or Guardian of camper,

On behalf of the Health Center staff at Word of Life Florida Youth Camp we would like to welcome you to camp! There are a few things you need to be aware of and help us with in order for our registration process to run smoothly on the first day of camp.

HEALTH FORM

- A Doctor's appointment is not necessary to complete this form.
- The health form provided to you must be completed in its entirety. Don't forget the backside.
- One or both parents or guardian must sign this form.

MEDICATIONS

- All medication must be turned in at registration.
- All prescription medications need to be properly labeled and in the original container for that specific camper.
- All medications need to be administered per doctor's order on the label. Any change in dosage or schedule need to be authorized in writing by the camper's physician, and turned in with the medication at registration.
- Please do not mix medications. Each medication needs to be in its original pharmacy container.
- All over the counter vitamins and medications such as Tylenol, Midol, or cough syrup must be in its original container and turned in to the nurse at registration.

HEALTH SCREENING

- Word of Life camps have a "No Nits" policy. Active cases of head lice need to be treated adequately prior to camp admission. If a camper is found to be with head lice or nits he or she will not be admitted into camp. Please inform your camper(s) not to share hairbrushes, hats or hair accessories.
- Please make the nurse aware at registration of any special health concerns for your camper(s).

If you have any questions please contact us at 727-856-7575.

Thank you for your cooperation in this matter.

Sincerely,

Word of Life Florida Youth Camp

Summer Camp HEALTH AND ACTIVITY RECORD

Please complete, sign, and date this form for all campers. **PLEASE DO NOT MAIL.**

(If form is incomplete, parents or guardian will be called collect.)

Please Print

| | | | | | | | | |
|--|---|------------|-------------------|----------------------------|--------------------------------------|--|--|--|
| LAST NAME | | | FIRST NAME | | | MIDDLE INITIAL | | |
| | | | | | | | | |
| SOCIAL SECURITY NUMBER | DATE OF BIRTH | AGE | MALE | FEMALE | WEEK(S) ATTENDING SUMMER CAMP | | | |
| | | | | | | | | |
| Group Information: | | | | | | | | |
| Group Name | | | | | | Group Leader | | |
| Is leader staying on campus during camp? Yes No | | | | | | | | |
| | | | | | | | | |
| Parent or Guardian | Full Name | | | | | Telephone Numbers With Area Codes | | |
| | | | | | | Home () | | |
| | Address | | | | | Work () | | |
| | City | | | State | | Zip code | | |
| IF NOT AVAILABLE IN AN EMERGENCY NOTIFY: (PREFERABLY RELATIVES) | | | | | | Telephone Numbers With Area Codes | | |
| Name | | | | | | () | | |
| Name | | | | | | () | | |
| Family Health Insurance Information | Name of Company | | | | Policy/Group Number | | | |
| | | | | | | | | |
| | Contact Person | | | | Telephone Number | | | |
| | | | | | () | | | |
| | Parents/Guardian Social Security Number (Required by Medical Facilities if under 18 years old) | | | | | | | |
| Parent/Guardian Name | | | | Social Security No: | | | | |
| SPECIAL MEDICAL PROBLEMS, CONDITIONS OR RESTRICTIONS: | | | | | | | | |
| | | | | | | | | |
| LIST MEDICINES BROUGHT TO CAMP (STATE LAW REQUIRES THAT ALL MEDICATION BE GIVEN TO THE CAMP NURSE. ALL MEDICATION MUST BE IN THEIR ORIGINAL CONTAINERS) | | | | | | | | |
| ALLERGIC TO: ▲ Penicillin ▲ Sulfa ▲ Aspirin ▲ Other | | | | | | | | |
| ANY FOOD ALLERGIES? If yes, explain. | | | | | | | | |
| IS CHILD TROUBLED WITH BED WETTING ? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| ABLE TO PURSUE ALL NORMAL ATHLETIC ACTIVITIES? If no, explain. | | | | | | | | |

CAMPER HAS OR HAS HAD THE FOLLOWING (INCLUDE YEAR OCCURRED):

_____ Chicken Pox _____ Epilepsy _____ Asthma

_____ Diabetes

Insulin Dependent
 Non-Insulin Dependent

Please provide proof of immunization history by indicating the dates of dosage on the following schedule

- **Proof of Measles** means **two** doses of measles vaccine on or after your first birthday and at least 30 days apart (preferably three months), **and/or a physician-documented history** of the disease or serologic evidence of immunity.
- **Proof of Rubella** means **one** dose of rubella vaccine on or after your first birthday or serologic evidence of immunity.
- **Proof of Mumps** means **one** dose of mumps vaccine on or after your first birthday, a **physician-documented history** of the disease, or serologic evidence of immunity.

IMMUNIZATION HISTORY

1st Dose 2nd Dose 3rd Dose 4th Dose Last Dose

Diphtheria & Tetanus Toxoid DT Five or more doses required. Most recent dose must be within 10 years prior to entry.

Polio Vaccine 5 (Live Oral Sabin) Minimum of four doses for those 18 years of age or under. For those 19 and over, record previous doses but no additional doses should be given.

| | | |
|--|----------------|---|
| Refer to Immunity Schedule Printed Above | Measles | Individuals will not be allowed to attend camp without complete immunization history |
| | Mumps | |
| | Rubella | |

Word of Life Camps are a non-profit charitable organization dependent on God and His people. Those who use Word of Life's facilities and/or engage in related activities, waive and release Word of Life Fellowship from any claim for personal injury or property damage. Attendees agree to carry insurance or have the resources to cover the expenses related to personal injury or property damage.

The health and immunization history is correct so far as I know. My son/daughter has permission to engage in all prescribed camp activities except as noted by me and the examining physician and has permission to leave the camp grounds for camp related outings and purposes. I realize that my campers picture and/or testimony may be used in the future promotion of Word of Life.

I understand that all medicines, vitamins, etc. must be given to the camp nurse upon arrival and that they must be in the original containers. Illegal drugs, weapons and similar items are not permitted at camp. Word of Life reserves the right to search for and remove such items from anyone suspected of possessing them.

I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests and treatment for my son/daughter, in the event I cannot be reached I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection, anesthesia, and/or surgery for my child as named above. **This form may be photocopied for use out of camp.**

Signature of Parent or Guardian: _____ **Date:** _____