

# 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 contacted before camper is admitted to camp.)

*Please Print*

<b>CAMPER LAST NAME</b>			<b>CAMPER FIRST NAME</b>			<b>CAMPER MIDDLE INITIAL</b>		
<b>DATE OF BIRTH</b>	<b>AGE</b>	<b>MALE</b>	<b>FEMALE</b>	<b>DATES ATTENDING SUMMER CAMP</b>				
<b>Group Information:</b>								
<b>Group Name</b>						<b>Group Leader</b>		
<b>Is leader staying on campus during camp?</b>		<b>Yes</b>	<b>No</b>	<b>Leader's Cell Phone:</b>				
<b>Parent or Guardian</b>	<b>Full Name</b>					<b>Telephone Numbers With Area Codes</b>		
						Home (    )		
	<b>Address</b>					Cell/Work (    )		
<b>City</b>					<b>State</b>		<b>Zip code</b>	
<b>IF NOT AVAILABLE IN AN EMERGENCY NOTIFY: (PREFERABLY RELATIVES)</b>						<b>Telephone Numbers With Area Codes</b>		
						Name (    )		
<b>Relationship to Camper</b>								

Do you have Health Insurance? YES  NO

If YES, please fill in the information below or attach a copy of front and back of insurance card.

<b>Family Health Insurance Information</b>	<b>Name of Company</b>			<b>Policy/Number</b>		
	<b>Group Number</b>			<b>Telephone Number</b>		
				(    )		
<b>Parent/Guardian Name</b>						

Does your child have any food/drug/environmental allergies? YES  NO  If yes please explain \_\_\_\_\_

**SPECIAL MEDICAL PROBLEMS, CONDITIONS OR RESTRICTIONS:**

Are they able to pursue all normal activities? YES  NO

If not explain:

Name of Family Physician or Medical Group: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Dentist or Orthodontist: \_\_\_\_\_ Phone: \_\_\_\_\_

If camper has had or currently has any of the following please check the box and include year of occurrence:

- |                                      |  |  |
|--------------------------------------|--|--|
| <input type="checkbox"/> Anemia      | <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Seizures/Epilepsy     |
| <input type="checkbox"/> Asthma      | <input type="checkbox"/> Bed Wetting         | <input type="checkbox"/> Diabetes              |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Emotional Treatment | <input type="checkbox"/> Insulin Dependent     |
|                                      |  | <input type="checkbox"/> Non-Insulin Dependent |

**IMMUNIZATION HISTORY**

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

<b>Diphtheria &amp; Tetanus (DTP, DTap, Pertussus, Td)</b> Most recent dose should be within 10 years.					
<b>Polio Vaccine</b>					
<b>MMR</b>					
<b>Hepatitis B</b>					
<b>Haemophilus Influenza B</b>					
<b>Varicella (Chicken Pox)</b>					
<b>Meningococcal Meningitis (optional)</b>					
<b>Other (please specify)</b>					

**Individuals will not be allowed to attend camp without complete immunization history**

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 understand that the camp nurse is not authorized to give injections of any kind and that my child must be able to administer his own injections if needed.

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:** \_\_\_\_\_

## Word of Life Camp Individual Medication Form

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_

The following may be administered to your child, if needed, while at camp.

Medication	Dosage	Approval
<b>Please check Yes or No</b>		
Acetaminophen (Compared to active ingredient in Tylenol)	per label instructions	YES <input type="checkbox"/> NO <input type="checkbox"/>
Ibuprofen (Compared to active ingredient in Advil)	per label instructions	YES <input type="checkbox"/> NO <input type="checkbox"/>
DiphenhydramineHCl (Compared to active ingredient in Benadryl)	per label instructions	YES <input type="checkbox"/> NO <input type="checkbox"/>
Guaifenesin (Compared to active ingredient in Robitussin or Mucinex)	per label instructions	YES <input type="checkbox"/> NO <input type="checkbox"/>

Parents or guardians please list your child's prescription medications, over the counter medications, Vitamins, herbs and or dietary supplements. **CAMPER MUST BE ABLE TO ADMINISTER OWN INJECTIONS.**

Mediation Name	Route	Dosage	Frequency and Indications	Comments
Additional Physician orders:				