

Health Form 2012



This form is due at camp **at least 2 weeks prior** to attendance.

Asbury Hills Camp & Retreat Center

Attn: Health Forms

150 Asbury Drive

Cleveland, SC 29635

FAX: 864.836.5522

Email: office@asburyhills.org

Phone: 864.836.3711

Name _____ Dates Attending Camp _____

 Last First Middle
Grade Entering in Fall _____ Age at camp _____ Birth date _____ Event Name _____

Home Address _____
 Street City State Zip

Social Security Number of participant _____ Gender: Male Female

Custodial parent/guardian _____ Phone _____

Home Address _____
(If different from above) Street City State Zip

Cell Phone _____ Business Phone _____

Second parent, guardian, or emergency contact _____

Address _____ Phone _____
 Street City State Zip

Cell Phone _____ Business Phone _____

If not available in an emergency, notify:

Name _____ Relationship _____

Address _____ Phone _____
 Street City State Zip

Insurance Information

Is participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name _____ Group # _____

Primary Name _____ Primary DOB _____

◆◆◆Photocopy of front and back of health insurance card must be attached to this form.◆◆◆

Name of family physician _____ Phone _____

Name of family dentist/orthodontist _____ Phone _____

Name of Medical Specialist _____ Phone _____

IMPORTANT—THIS BOX MUST BE COMPLETE FOR ATTENDANCE

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

Permission to Provide Necessary Treatment or Emergency Care:

I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. *(The completed forms may be photocopied for trips out of camp and for doctor and emergency room use).

1. I have read the instructions for the parents and give permission for the medical staff to provide treatment in the infirmary for accidents or illness according to policies and procedures of the camp.
2. I have provided any written instructions necessary for the medical personnel on this health form.
3. I also give permission to the medical personnel to administer over the counter medications (as listed on page 2) as deemed appropriate according to the camper's complaints or condition.
4. I understand that my designee or I must be available to pickup my camper during their time at camp should a medical or behavioral problem arise.
5. *Note: Parents will be contacted if the camper has an illness or accident that is of concern to the Health Officer and Director. Parents will be contacted/consulted in the event that a trip to Urgent Care, Emergency Room, or other off site medical attention is necessary. In the event that the parents cannot be reached, the Health Officer or Director will try to reach an Emergency Contact Person.

Signatures of all custodial parents or legal guardians, or of adult event participant/staffer _____

Please Print Name(s) _____ Date _____

Camper Name _____ Dates Attending Camp _____
(Please Print) Last First

Health History

The following information must be filled in by the parent/guardian, or adult camper or staff member. The intent of this information is to provide appropriate care. Please keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon arrival at camp. This information will be shared with your child's counselor. Please provide complete information you feel may be helpful to them. **All questions and blanks MUST be filled in or answered with at least "Yes", "No" or "N/A".**

Allergies (List all known) Describe reaction and management of the reaction.

Medication Allergies, Food Allergies and Other Allergies (list, including insect stings, hay fever, asthma, ivy poisoning, animal dander, etc.).

Restrictions

Does your child have any dietary restrictions that apply to this individual (e.g. vegetarian, lactose intolerance, etc.)? Yes No
Please list:

Are there any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)? Yes No
Please explain if yes:

Are there fears or concerns should we assist your child in dealing with (e.g. homesickness, sleepwalking, etc.)? Yes No
Please list:

Does your child have any as-needed medications (inhaler, Epi-Pen, etc) your camper's counselor will need to carry with them? Yes No
Please list:

Over The Counter Medications to be Administered if Needed While at Camp: (please check yes if medicine can be administered)

<u>Camper Complaint</u>	<u>Medicine Administered</u> (May be generic equivalent)
Yes <input type="checkbox"/> No <input type="checkbox"/> Minor aches & pains, headaches, toothaches or elevated temperature	Motrin or Tylenol
Yes <input type="checkbox"/> No <input type="checkbox"/> Itching, rash, poison ivy, insect bites or sunburn	Benadryl, Calamine, Aveno, 1% Hydrocortisone Cream, Aloe
Yes <input type="checkbox"/> No <input type="checkbox"/> Mild diarrhea (w/o other symptoms)	Imodium
Yes <input type="checkbox"/> No <input type="checkbox"/> Upset stomach	Tums, Pepto Bismal
Yes <input type="checkbox"/> No <input type="checkbox"/> Minor cuts, scratches, abrasions	Triple antibiotic (Neosporin), Sterile Wipes
Yes <input type="checkbox"/> No <input type="checkbox"/> Mosquito, insect bites	Insect repellent, Skeeter Stik, After Bite
Yes <input type="checkbox"/> No <input type="checkbox"/> Itchy, watery eyes, sneezing, runny nose	Benadryl tablet
Yes <input type="checkbox"/> No <input type="checkbox"/> Stuffy nose	Sudafed
Yes <input type="checkbox"/> No <input type="checkbox"/> Sore throat	Throat lozenges
Yes <input type="checkbox"/> No <input type="checkbox"/> Sun exposure	Sunscreen

The following person(s) is (are) authorized to pick up my child at the completion of camp (please include yourself):

(Please Print) _____

AH Use Only

Camper Pick Up:
Released to _____ AH Staff _____ Date _____

Camper Name _____ **Cabin** _____
(Please Print) Last First (Office Use Only)

***We will be checking IDs at the entrance to camp.**

