Health Form

CAMP KIDJAM

Dates attendee will be at camp: 7/17/17 (Month/Day/Year) to 7/20/17 (Month/Day/Year)

Name of attendee: _____ (First) _____ (Middle) _____ (Last)

❒ Male ❒ Female Birth date: _____ Age on arrival at camp: _____

Home address:

_____ (Street address) _____ (City) _____ (State) _____ (Zip)

Parent/legal guardian/spouse to be contacted in case of illness or injury:

Name: _____ Relationship to attendee: _____ Phone number: (____) ____-_____

Home address:

_____ (if different from above) (Street address) (City) (State) (Zip)

Second parent/legal guardian or other emergency contact:

Name: _____ Relationship to attendee: _____ Phone number: (____) ____-_____

Allergies: ❒ No known allergies. ❒ Attendee is allergic to: ❒ Food ❒ Medicine ❒ Environment (insect stings, pollen, etc.)
(If attendee has allergies, please describe below what the camper is allergic to and the reaction seen.)

Diet, Nutrition: ❒ This attendee eats a regular diet. ❒ This attendee eats a regular vegetarian diet.
❒ This attendee has special food needs. **(Please describe below.)**

Restrictions: ❒ I have reviewed the program and activities of the camp and authorize the attendee to participate without restrictions.
❒ I have reviewed the program and activities of the camp and authorize the attendee to participate with the following restrictions or adaptations. **(Please describe below.)**

Medical Insurance Information: Although it is not mandatory, we recommend that every attendee, leader or child, has health insurance. **Please attach a copy of your insurance card to this form. Copy both sides of card, if necessary.**

Medication: ❒ This attendee will not take any daily medications while attending camp.
❒ This attendee will take the daily medications listed below while at camp.
"Medication" is any substance a person takes to maintain and/or improve health. This includes vitamins and natural remedies. **The attendee's medication must be in the original container with their name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.**

Name of Medication	Date Started	Reason for Taking It	When It Is Given	Amount/Dose Given	How It Is Given
			❒ Breakfast ❒ Lunch ❒ Dinner ❒ Bedtime		
			❒ Breakfast ❒ Lunch ❒ Dinner ❒ Bedtime		

The following non-prescription medications may be stocked in the Camp KidJam First Aid Office and are used on an as-needed basis to manage illness and injury. **Cross out those the attendee should NOT be given.**

Acetaminophen (Tylenol)
Ibuprofen (Motrin, Advil)
Phenylephrine decongestant (Sudafed PE)
Pseudoephedrine decongestant (Sudafed)
Antihistamine/allergy medicine (Benadryl)
Guaifenesin cough syrup (Robitussin)
Generic cough drops
Calamine lotion
Antibiotic cream (Neosporin)
Aloe
Lidocaine topical (Solarcaine)
Calcium carbonate (TUMS)
Bismuth Subsalicylate (Pepto Bismol)
Anti-nausea medicine (Emetrol)
Anti-diarrheal medicine (Imodium AD)

Name: _____ First _____ Middle _____ Last
Church Name: _____
Team Color: _____

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Name: _____
First Middle Last

❒ Male ❒ Female Birth date: _____

Immunization History: Provide the month and year for each immunization. Starred (★) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach it to this form. **Adults (18 years of age or older) do not need to complete this section of the form.** If any attendee has not been immunized, please sign the section below.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, tetanus, pertussis ★ (DTaP) or (TdaP)						
Tetanus booster ★ (dT) or (TdaP)						
Mumps, measles, rubella ★ (MMR)						
Polio ★ (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella ❒ Had chicken pox (chicken pox) Date:						
Meningococcal meningitis (MCV4)						
H1N1 vaccine (Swine flu)						

Tuberculosis Test (TB)	Date:	❒ Negative	❒ Positive

If the attendee has not been fully immunized, please sign the following statement: **I understand and accept the risks to the attendee from not being fully immunized.**

Signature of attendee: _____ Date: _____
(if over 18 years of age)

Signature of parent/legal guardian: _____ Date: _____

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does the attendee:

1. Ever been hospitalized?	❒ Yes	❒ No	11. Had fainting or dizziness?	❒ Yes	❒ No
2. Ever had surgery?	❒ Yes	❒ No	12. Passed out/had chest pain during exercise?	❒ Yes	❒ No
3. Have recurrent/chronic illnesses?	❒ Yes	❒ No	13. Had mononucleosis (mono) during the past 12 months?	❒ Yes	❒ No
4. Had a recent infectious disease?	❒ Yes	❒ No	14. If female, have problems with periods/menstruation?	❒ Yes	❒ No
5. Had a recent injury?	❒ Yes	❒ No	15. Have problems with falling asleep/sleepwalking?	❒ Yes	❒ No
6. Had asthma/wheezing/shortness of breath?	❒ Yes	❒ No	16. Ever had back/joint problems?	❒ Yes	❒ No
7. Have diabetes?	❒ Yes	❒ No	17. Have a history of bedwetting?	❒ Yes	❒ No
8. Had seizures?	❒ Yes	❒ No	18. Have problems with diarrhea/constipation?	❒ Yes	❒ No
9. Had headaches?	❒ Yes	❒ No	19. Have any skin problems?	❒ Yes	❒ No
10. Wear glasses/contacts/protective eyewear?	❒ Yes	❒ No	20. Traveled outside of the country in the past nine months?	❒ Yes	❒ No

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside of the country, please name the countries visited and the dates of travel.

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Name: _____
First Middle Last

❒ Male ❒ Female Birth date: _____
Month/Day/Year

Mental, Emotional and Social Health: Check "Yes" or "No" for each statement.

Has the attendee:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD)?	❒ Yes	❒ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?	❒ Yes	❒ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?	❒ Yes	❒ No
4. Had a significant event that continues to affect the attendee's life? (death in the family, divorce, adoption, new sibling, etc.)	❒ Yes	❒ No

Please explain "Yes" answers in the space below, noting the number of the questions.

What have we forgotten to ask? Please provide any additional information about the attendee's health that you think important or that may affect the attendee's ability to fully participate in the camp program. Attach additional information, if needed.

Consent to participate in camp: Please check one.

❒ I consent to the attendee's full participation in camp activities. I do not believe that any conditions listed in this Health Form increase the risk to the attendee of camp activities beyond what is normal and acceptable to me.

❒ I do not consent to the attendee's full participation in camp activities. I believe certain conditions listed in this Health Form may increase risk to the attendee of camp activities beyond what is normal and acceptable to me.

Authorization for Healthcare and Photo/Video Release

This Health Form accurately reflects the health of the attendee. I authorize Camp staff, medical providers (including physicians and EMTs) and/or my emergency contacts to authorize medical care and treatment, including invasive tests and/or surgery, for the attendee as any of them believe is reasonably necessary for the attendee's health and safety if I cannot be reached immediately. On behalf of the attendee, and his/her family, I release Camp KidJam, The reThink Group, Inc., and their employees, interns, directors, contractors, volunteers and all medical providers ("Camp Parties"), to the maximum extent legally permitted, from all claims arising from the attendee's medical care or treatment and I indemnify the Camp Parties from any claims, costs, damages, expenses or losses. I authorize information on this form to be photocopied and/or shared with Camp Parties. I authorize the attendee's health-care providers to discuss and/or copy the attendee's health-care records for Camp Parties. I understand that the attendee may be photographed or video taped during camp and that these images may be used in promotional materials.

Signature of attendee: _____ Date: _____
(if over 18 years of age)

Signature of parent/legal guardian: _____ Date: _____

Relationship to attendee: _____

Parents/Guardians: STOP here. The rest of this form is to be completed at camp. Keep a copy of this form for your records.

CAMP KIDJAM

Health Form

Name: _____
First Middle Last

❒ Male ❒ Female Birth Date: _____

Provider Notes: (Date/time/treatment given/initials)