ECC Summer Camp

Health Questionnaire & Consent

THIS FORM IS TO BE COMPLETED BY THE PARENT/GUARDIAN AND BROUGHT TO CAMP WITH COPY OF HEALTH INSURANCE.

Camper's Name ____ Sex _________ Birth date __________
last first middle

Home Address ____

City ____ State _______ Zip ______________

Parent/Guardian Name ____

Home Phone ( ) ______________________ Business Phone ( ) _________________________

If not available, in an EMERGENCY contact:

Name ____ Phone ( ) ___________________________

Part One --- Parental Authorization

I understand and certify that my child's participation in the summer camp program is completely voluntary. I understand that certain hazards and dangers are inherent in the camp program, and I acknowledge that although the Evangelical Christian Center has taken measures to minimize the risk of injury to camp participants, ECC cannot guarantee that the activities will be free of accidents or injuries. Furthermore, I have instructed my child in the importance of abiding by the camp's rules and procedures for the safety of camp participants.

I understand that parents are contacted in the event their child receives professional medical attention. In the event that I cannot be reached in an EMERGENCY, I hereby give permission to the attending physician secured by ECC Christian Center to hospitalize, secure proper treatment for, and to order injections, anesthesia, or surgery for my child.

Signature of Parent ____ Date _____________________

If you carry medical insurance, PLEASE PROVIDE COPY OF INSURANCE CARD FOR EACH CHILD.

Insurance Carrier ____ Policy # ___________________

Insurance Carrier Phone Number ( ) __________________________

Policy Holder's Name ____ SS# ______________________

Part Two --- Health Information

Basic Health History:

- ☐ frequent ear infections
- ☐ heart defect
- ☐ hypertension
- ☐ asthma
- ☐ convulsions
- ☐ bedwetting
- ☐ bleeding disorders
- ☐ epilepsy
- ☐ sleepwalking
- ☐ diabetes
- ☐ hyperactivity

Allergies:

- ☐ penicillin
- ☐ hay fever
- ☐ other (specify):
- ☐ serious poison ivy
- ☐ food allergies
- ☐ bee stings
- ☐ aspirin

Immunizations: All immunizations must be up to date. Indicated dates of basic immunization or most recent booster.

_______ DPT _______ Polio _______ Measles

_______ Current Tetanus (If date cannot be supplied, please initial this statement: "In case of an emergency, the attending physician may administer a tetanus booster." _)

Operations, Serious or Chronic Illnesses:

Dietary Modifications While At Camp:

Part Three --- Health Examination Record

This health history record is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted by me. I also attest that the person herein described has had a medical examination within the past 3 years.

Physical Restrictions: Date of Last Physical _______________

Parent's Signature ____ Date ____________________

Name & Phone # of Family Physician ____________________________ ( ) __________________

Part Four --- Youth Camp Health Exam

A Health Exam form **signed by a Physician** is required for camp. The exam must have been given within the last 3 years to be valid. This form must be completed for camper to participate.

First Name ___________________ Last Name_________________________ DOB _____________________

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER

DATE OF EXAM ______/______/_______

_____ May participate in all camp activities _____ May participate except for _________________

____

Medical Information pertinent to routine care and emergencies: _____________________________________

____

Is this Individual taking prescription or over the counter medication(s)? ☐ Yes ☐ No

If yes, indicate names of medication(s): ____

Does this individual have allergies? ☐ Yes ☐ No Explain: __________________________________

Is this individual on a special diet? ☐ Yes ☐ No Explain: __________________________________

Does this individual have special needs? ☐ Yes ☐ No Explain: __________________________________

This camper is up-to-date on all of the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	Yes	No		Yes	No
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Pneumococcal		
Tetanus			Polio		

Comments: ____

____

Print Name of Medical Care Provider ____

Address____ Phone__________________________

____ ____

Signature of Physician, PA, APRN or RN Date Form Signed