



Lancaster Presbyterian Church

Name _____		
Office Use Only	<input type="checkbox"/> Elementary	Cabin # _____
	<input type="checkbox"/> Intermediate	Tent # _____
	<input type="checkbox"/> Junior High	Lodge or Cabin # _____
Dates of Camp: <u>Sunday, June 24 – Saturday, June 30, 2018</u>		

# Information & Health History

## Summer Youth Camp 2018

**Name of Camper:** \_\_\_\_\_

*This will assist the Camp Medical Staff give appropriate care, so any changes should be provided to the Camp Nurse upon arrival.*

### General Information:

Name of Camper: Last \_\_\_\_\_ First \_\_\_\_\_

Home Address: \_\_\_\_\_

Street City State Zip

Home Phone \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade Completed \_\_\_\_\_

Parents/Guardians (Custodial): \_\_\_\_\_

Phone Number (Mother) \_\_\_\_\_ (Father) \_\_\_\_\_

Email (Mother): \_\_\_\_\_ (Father) \_\_\_\_\_

### Emergency Contact Information: (If unable to reach a parent; name someone who is available all the time)

1<sup>st</sup> Contact Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

2<sup>nd</sup> Contact Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

### Health Insurance Information:

Health Insurance Company: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to participant: \_\_\_\_\_

ID #: \_\_\_\_\_ Group No: \_\_\_\_\_

***A photocopy of the insurance card is required with this form.***

Camper's Physician: \_\_\_\_\_ Phone \_\_\_\_\_

Camper's Dentist: \_\_\_\_\_ Phone \_\_\_\_\_

Camper's Orthodontist: \_\_\_\_\_ Phone \_\_\_\_\_

**Parent/Guardian Authorizations:** This health history is correct and complete to the best of my knowledge, and the person herein described has permission to engage in all camp activities except as noted on this form. I hereby give permission to the medical personnel selected by the Camp Director to secure proper treatment and transportation, for my child named above if deemed necessary. I also give permission to share their medical information for this purpose.

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print parent/guardian name



Lancaster Presbyterian Church

Name \_\_\_\_\_

Office Use Only  Elementary  Intermediate  Junior High

Cabin # \_\_\_\_\_ Tent # \_\_\_\_\_  
Lodge or Cabin # \_\_\_\_\_

Dates of Camp: Sunday, June 24 – Saturday, June 30, 2018

# Information & Health History

## Summer Youth Camp 2018

Name of Camper: \_\_\_\_\_

*This will assist the Camp Medical Staff give appropriate care, so any changes should be provided to the Camp Nurse upon arrival.*

**Has the camper traveled outside the country in the past 9 months?**

- Yes If Yes, where to? \_\_\_\_\_
- No

**General Questions:** (For questions answered as "yes", please explain on the right or attach another page.)

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| 1. Had recent injury, illness or infectious disease?                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Have a chronic or recurring illness/condition?                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Ever been hospitalized or had surgery?                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Have frequent headaches?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Ever had a head injury or been knocked unconscious?              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Wear glasses or contacts   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Ever had frequent ear infections?                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Ever pass out or been dizzy during or after exercise?            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Ever had seizures or convulsions?                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Ever had chest pains during or after exercise?                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Ever had high blood pressure?                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Ever been diagnosed with a heart murmur or heart condition?     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. Ever had back problems?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. Ever had joint problems?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. Bringing an orthopedic device to camp?                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 16. Have any skin problems?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 17. Have diabetes?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 18. Have asthma?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 19. Had mononucleosis in past 12 months?                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 20. Had problems with diarrhea/constipation?                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 21. Problems with sleepwalking or bed wetting?                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 22. If female – abnormal menstrual history?                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 23. Ever had emotional problems for which professional help sought? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 24. Ever had an eating disorder?                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 25. Bee sting reactions?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 26. Hay fever or other allergies?                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**Parent/Guardian Authorizations:** This health history is correct and complete to the best of my knowledge, and the person herein described has permission to engage in all camp activities except as noted on this form. I hereby give permission to the medical personnel selected by the Camp Director to secure proper treatment and transportation, for my child named above if deemed necessary. I also give permission to share their medical information for this purpose.

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print parent/guardian name