SHELDON CALVARY CAMP – CAMPER HEALTH FORM 2025

Please use one form for each child – please copy as necessary

NOTE: The Release for Emergency Treatment on the reverse side must be signed by a parent/guardian.
Without your signature, your camper will not be allowed to fully participate in camp activities.

CAMPER'S NAME: _____

SESSION #: _____

PERSONAL INFORMATION

Camper's Name: _____ Birthday: ___/___/_____ Gender: _____ Age: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Parent/Guardian 1 Name: _____ Parent/Guardian 2 Name: _____

Home Phone: (___)____-_____ Parent 1 Daytime/Cell: (___)____-_____ Parent 2 Daytime/Cell: (___)____-_____

Emergency Contact: _____ Relationship: _____ Phone: (___)____-_____

Camper's Doctor/Clinic: _____ Phone: (___)____-_____

Do you carry medical insurance? Circle: Yes No Carrier: _____

Policy #: _____ Group ID: _____ Member Services Phone: (___)____-_____

Primary Insured Name: _____ Primary SSN: ___-___-_____ Birthday: ___/___/_____

Preferred drug store? Circle: CVS RiteAid WalMart Giant Eagle Walgreens

PARTICIPANT'S HEALTH HISTORY: PLEASE CHECK AND EXPLAIN ANY "YES" REPLIES BELOW

Asthma	☐ YES	☐ NO	Ear Infections	☐ YES	☐ NO	Headaches	☐ YES	☐ NO
Heart Defect/ Disease	☐ YES	☐ NO	Head Lice (past 6 months)	☐ YES	☐ NO	Tuberculosis	☐ YES	☐ NO
Seizures	☐ YES	☐ NO	Bed Wetting	☐ YES	☐ NO	ADD/ADHD	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO	Sleep Walking	☐ YES	☐ NO	Depression	☐ YES	☐ NO
Recent Hospitalization	☐ YES	☐ NO	Fainting	☐ YES	☐ NO	Eating Disorders	☐ YES	☐ NO

DETAILS OF ANY "YES" REPLIES ABOVE: _____

PLEASE GIVE THE DATE OF THE FOLLOWING IMMUNIZATIONS OR ILLNESSES:

	Immunization	Illness		Immunization	Illness
DPT, TD or Tetanus	_____	_____	Hepatitis B	_____	_____
Measles, Mumps, Rubella	_____	_____	Chicken Pox	_____	_____
Polio	_____	_____	Other: _____	_____	_____

ALLERGIES: List all food, drug, and insect allergies: (please indicate types and date of reaction(s) and indicate how treated)

_____

List recent illnesses (past two months): _____

List current medications and dispensing instructions: _____

Is there any special medical or dietary care needed? _____

List any restrictions for camp activities (swimming, games, etc.): _____

Please use the space below to provide any additional information that may help us care for our child during camp:

_____

!! VERY IMPORTANT !!
BOTH SIDES MUST BE COMPLETED!

THE FOLLOWING **MUST** BE COMPLETED FOR YOUR CHILD TO FULLY PARTICIPATE IN CAMP ACTIVITIES.

Unless this form is signed by a parent or guardian, the camp cannot get emergency help for your child in case of injury.

I certify that this health history is correct and complete as far as I know. I understand that the Calvary Camp program includes archery, photography, gardening, low ropes initiative activities, sailing paddleboarding, paddleboating, and kayaking (for children 12 years and older), recreational athletics, fishing, wilderness skills, tennis, arts and crafts, and swimming. By signing below, I give my permission for the camper named below to engage in all camp activities except as noted on reverse.

I also hereby give permission to the camp to provide, seek, and consent to routine health care by the camp healthcare provider under the standing orders of the camp physician, for the administration of prescribed medication, and emergency treatment for the camper named below as may be necessary including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purpose of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree to the disclosure to camp representatives of the protected health information of the camper named below as necessary to provide relevant information to the camp representatives related to the camper's ability to participate in camp activities and to provide relevant information to the camp representatives to keep me informed of my child's health status.

I give permission for the camper named below to be transported in camp vehicles for emergencies and to approved off-campus activities. I give permission for the use in camp publicity of photographs and video which include my child, both in print and on the camp website *www.calvarycamp.org*. In Calvary Camp publicity materials, individual campers will not be identified.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the camper named below.

Camper Name _____ **Signature of Parent or Guardian** _____

Printed Name _____ Date _____

THIS SECTION FOR CAMP USE ONLY

Please do not write below this line

I. Administration of Medicines:

Medication Time(s) given Date:														

II. Visits to the Wellness Center: (including date, time, complaint, assessment and treatment given.)

_____

_____

_____

_____

_____

_____

_____

_____

III. Initial Health Screening

I have reviewed this form, conducted an initial health screening of this camper, and have reviewed all medications submitted.

Signed _____ Date _____