

Camp Perkins Health Form

This form must be on file with Camp Perkins prior to participation in any programming.

Participant Last Name _____ First Name _____ Date of Birth _____
 Gender: M () F () Height _____ feet _____ inches Weight _____ lbs Camp Program Attending _____ Attending Date _____
 E-Mail Address _____ Address _____ City/State/Zip _____
 Mother's Full Name (if under 18) _____ Phone _____ Cell Phone _____ Lives with participant? **Yes No**
 Father's Full Name (if under 18) _____ Phone _____ Cell Phone _____ Lives with participant? **Yes No**
 Emergency Contact Name _____ Relationship to Camper _____
 Phone _____ Cell Phone _____ In case of emergency, whom should we call first? _____

Current Medications: Please note, all prescription medications MUST be prescribed to this individual. All medications must be within expiration date and in original packaging.

Name of Medication	Reason for Taking	Dosage	Schedule

Health History

Condition	Circle One	If Yes:	Condition	Circle One	If Yes:	Condition	Circle One	If Yes:	Condition	Circle One	If Yes:	Condition	Circle One	If Yes:
Anxiety or Depression	No Yes	Current Past	Recurrent Headaches	No Yes	Current Past	Heart Disease or Problems	No Yes	Current Past	Diabetes	No Yes	Current Past	ADD or ADHD	No Yes	Current Past
Epilepsy or Convulsions	No Yes	Current Past	Asthma	No Yes	Current Past	Frequent Colds	No Yes	Current Past	Frequent Ear Infections	No Yes	Current Past	Bed Wetting	No Yes	Current Past
Ear, Nose, or Throat trouble	No Yes	Current Past	Disease or injury to joints or back	No Yes	Current Past	Stomach or Intestine trouble	No Yes	Current Past	Dizzy Spells or Fainting	No Yes	Current Past	Home Sickness	No Yes	Current Past
Eating Disorders	No Yes	Current Past	Comments, other issues, physical limitations and/or list surgeries											

Allergies and Dietary Needs

Type of Allergy	Circle One	Describe/Specify Allergen	Mild (Runny Nose, sneezing)	Moderate (Swelling or severe rash)	Severe (Systemic Response/Difficulty breathing)
Food	No Yes				
Medication	No Yes				
Environmental (animal, plant, insect, etc.)	No Yes				
Other	No Yes				

Vegetarian? No Yes Limitations: _____ Gluten Allergy? No Yes Limitations: _____ Lactose Intolerant? No Yes Limitations: _____

Immunizations: You do not need to attach a copy of immunization history.

Vaccination	Most Recent Date	Date of last Physical Exam:
Influenza		Physician Name: _____
Diphtheria/ Tetanus (DPT)		Physician Phone: () _____

Photo Release

If you **do not** want this individual to be used in any photo or video image in Camp Perkins' promotional material (photos, video, or website), please circle "Do Not Use" below and initial. If circled, the participant will be excluded from ALL camp photos and videos.

Do Not Use Initials: _____

Consent for Medication

Do you authorize the Camp Perkins staff to provide over-the-counter medication and topical creams according to package directions to this individual? **Yes No**
 Is there any medication that you do not want camp staff to provide? _____

Medical Insurance: Does this person have medical insurance? **Yes No**

IF YES, please attach a copy of both the front and back of your health insurance card.
IF NO, please attach a signed letter stating that you agree to pay for any medical costs in the event of an emergency. These costs are not in any way covered by Camp Perkins.

Authorization

I hereby give informed and expressed consent for this individual to take part in all camp activities under supervision, and agree that the camp or camp personnel will not be held responsible for accidents arising there from. I authorize the camp Health Care Provider and/or designated camp staff to provide appropriate treatment to this individual for injuries and/or illness. This includes, but is not limited to, following Camp Perkins medical procedures and protocols, following poison control recommendations, administering prescription medications as noted above, administering over the counter medications as approved above, transportation to clinic or hospital care, and following directions from the medical director. I understand that the information on this form may be released to the appropriate medical personnel in case of emergency. I agree to pay any cost for medical care in the event of an emergency, even if I do not have health insurance coverage or not all costs are covered by insurance. I also understand that failure to disclose medical or emotional problems in advance may lead to serious consequences while at camp. Lastly, I verify that everything contained on this form is complete and accurate, to the best of my knowledge.

Parent/Guardian Signature

OR Participant Signature if over 18

Date _____