WPAUMC

Day Camp Program

Health History and Medical Information Form

for Children, Youth and Adults Volunteers

I/We as parent(s)/guardian(s), hereby agree to allow the sharing of any information contained in this form as regards myself/my child/dependent. I realize this will be done with the utmost discretion and by the sharing will provide the best and safest experience for myself/my child/dependent.

Signature ____ ***Date*** ____________

Camper/Volunteer's Name____
Last First Middle

Gender: ________ Birth date__________________________ Age during event____________________

Home address____
Street Address City State Zip

Custodial parent/guardian (if under 18)____ Phone (____)________________

Home address____
(if different from above) Street Address City State Zip

Business Name____ Business/Cell phone (____)____________

Business Address____
Street Address City State Zip

Emergency contact (or second parent/ guardian)____

Address____ Phone (____)________________
Street Address City State Zip

Business address____ Business/Cell phone (____)____________
Street Address City State Zip

If the above are not available in an emergency, notify____

Relationship____ Phone (____)________________

Address____
Street Address City State Zip

Family Physician____ Phone (____)________________

Insurance Information
Is the participant covered by family medical/hospital insurance? Yes□ No □
If so, indicate carrier or plan name ____ Group #____________________

HEALTH HISTORY

ALLERGIES: List all known. Describe reaction and management of the reaction.

Food allergies (list)

________________________ ____

________________________ ____

Other allergies (list)-include insect stings, medications, hay fever, animal dander, etc.

________________________ ____

________________________ ____

History of any of the following:

☐Asthma or any breathing problem ☐Diabetes ☐Headaches ☐Seizures ☐Motion Sickness

Please note any other medical history you feel will be helpful____

____

____

MEDICATIONS BEING TAKEN

Please list ALL medication (including over-the-counter or nonprescription drugs) taken routinely. Bring any medications that may need to be administered while at Day Camp. **Keep <u>ALL</u> medications, both prescription and non-prescription drugs, in their original packaging/containers.**

☐ This person takes **NO** medication on a routine basis.

☐ This person takes medications as follows:

Med # 1______________________ Dosage________________ Specific times taken each day______________________________

Reason for taking____

Med # 2______________________ Dosage________________ Specific times taken each day______________________________

Reason for taking____

Please attach additional pages if more medications are taken.
Identify any medications taken during the school year that participant does/may not take during the summer:_______________

____

PHYSICAL/ACTIVITY RESTRICTIONS

The following restrictions apply to this individual ____

____

Explain activity restrictions (e.g., what cannot be done, what adaptations or limitations are necessary)_______________________

____

DIETARY RESTRICTIONS

☐ No ☐ Yes (describe) ____

Are all immunizations up to date ☐ Yes ☐ No

Has camper been exposed to any contagious diseases in the last 4 weeks ☐ Yes ☐No If yes, to what ____________________

Accommodations

Explain any additional accommodations that will be needed ____

____

____

Camper/Volunteer's Name______________________ ________ ______________ ________ Day Camp Program
First Last

Important – These boxes must be complete for attendance*

This health history is correct and complete as far as I know. The person herein named has permission to engage in all WPAUMC Day Camp Program activities except as noted.

I hereby give permission to the WPAUMC Day Camp Program leadership to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the Day Camp Program leadership to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the WPAUMC Day Camp Program leadership be treated as acting in *loco parentis* if the person herein named is a minor and I am not present. Further, it is my intention that the appropriate representatives of the WPAUMC Day Camp Program be treated as "personal representatives" for the purposes 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 (pursuant to 45 CFR § 164.510(b) to the disclosure to the WPAUMC Day Camp Program representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the WPAUMC Day Camp Program representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the WPAUMC Day Camp Program representatives to keep me informed of my child's health status.

In the event I am not present and/or cannot be reached in an emergency, I hereby give permission to the physician selected by the WPAUMC Day Camp Program leadership to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied.

Signature of parent or guardian or independent adult participant____

Printed Name ____ Date__________________

I, or as parent or legal guardian on behalf of the person herein named, accept the conditions stated, including the release of the W PA UMC, the WPAUMC Day Camp Program, and the local church in which this program is held, from liability in case of accident or illness. I give permission for the person's herein named picture in camp activities to be used in brochures, publications and visual presentations promoting the WPAUMC Day Camp Program. I give my consent for the person herein named to participate in any off-site activity during the WPAUMC Day Camp Program. Transportation to and from these activities will be provided via professional bussing services, with professional drivers, which will be under the supervision of at least two (2) WPAUMC Day Camp Program staff members.

Signature of parent or guardian or independent adult participant____

Printed Name ____Date____________