Camp Wesley Woods Health Form

Please complete all parts

Name ______________________________

Birth Date:______________________Gender:______________ Age:______________

Insurance Company:______________________________Policy #______________

Insurance Subscriber's Name:______________________________

Insurance Claims Address:______________________________

Pre-Authorization Phone # if required (____)______________________________

Emergency Contact:______________________________Home Phone: (____)______________

Address:______________________________Work Phone: (____)______________

City:______________________State:________Zip:____________Cellular Phone: (____)______________

In an emergency situation, use these contacts as necessary:

Second Contact:______________________________Home Phone: (____)______________

Work Phone: (____)______________________Cellular Phone:(____)______________________

Emergency Contact:______________________________

Home Phone: (____)______________________Work Phone:(____)______________________

Camper's Physician:______________________Phone: (____)______________________

Have you ever had the following? If so, write in the date.

Ear Infections:______________ Chicken Pox:______________ Measles:______________

Frequent Headaches:______________ Mumps:______________ Convulsions:______________

Bleeding Disorders:______________ ADD/ADHD:______________ Fainting:______________

Operations:______________________________ Diabetes:______________

Serious Injuries:______________________________ Other:______________

Mouth Braces:______________Is Camper a sleepwalker:______________

Have you ever had an allergic reaction to: (describe)?

Hay fever:______________Ivy Poisoning:______________ Insect Stings:______________

Penicillin:______________Other Drugs:______________________________

Asthma:______________Foods:______________________________

Other:______________________________

Does you have other special considerations?

Chronic or recurring illness:______________________________

Emotional or behavioral problems:______________________________

____

Activities encouraged or limited:______________________________

Special Diet:______________________________

Other:______________________________

Immunization History - Give date of most recent immunization or booster:

Tetanus:______________ Tetanus Booster:______________Polio:______________

Mumps:______________ Measles:______________ Rubella:______________

DPT:______________ Hepatitis B______________ Tuberculin Test:______________

Other:______________________________

Name______________ Group______________ Date______________

All medications brought to camp, both prescription and non-prescription, must be in the original containers and clearly labeled with name. All prescription medications will be dispensed according to physician's instructions.

Prescription and Routine Medications – Please list all medications you brought to be taken regularly throughout your stay listing exact dosage and dispensing orders prescribed by your doctor.

Medication	Dosage	Times Taken (Breakfast, Lunch, Supper, Bed, Other)

This health history is correct so far as I know.

In signing this authorization, I acknowledge that I am aware that the activities associated with this event entail certain inherent risks including damage to property, personal injury, and even death. In consideration for being permitted to participate in this event, I agree to assume all such risks and hereby release and discharge Holston Conference Camping and Retreat Ministries, Inc., it's affiliated camps, officers, sponsors, trustees, employees, agents and other aids and/or volunteers from any and all liability for any and all damage, loss, injury, or death of every kind and nature whatsoever which in any way arises out of my participation in this event.

The person herein descried has permission to engage in all prescribed camp activities except as noted.

I hereby give permission to the chaperone to provide routine health care, administer prescription drugs, and seek emergency medical treatment including ordering X-rays and/or routine tests. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the chaperone to hospitalize, secure proper treatment, and to order injection and/or anesthesia and/or surgery for me/or my child as named above.

I give permission for me/my child to be transported in a private vehicle if necessary.

I give permission for photographs taken of me/or my child to be used by Camp Wesley Woods for camp publicity.

Signature of parent/guardian or adult guest: ____

Date__________________________________