Camp Christian Health and Participation Form

General Information

Full Name of Participant		Date of Birth	

Street Address	
City, State, Zip	

Church Name		Adult Leader from Church	

Name of Camp		Location	
Dates of Camp			

Parent/Guardian Information (Participants 18 & over may skip to the Emergency Contact section below)

Name of Parent/Legal Guardian			
Street Address			
City, State, Zip			
Home Phone (include area code)		Mobile Phone	

Name of Employer	
Employer Address	
Work Phone Number	

Name of Parent/Legal Guardian			
Street Address			
City, State, Zip			
Home Phone (include area code)		Mobile Phone	

Name of Employer	
Employer Address	
Work Phone Number	

Emergency Contact & Transportation Information (OTHER than Parent(s)/Guardian(s) listed above)

Name		Relationship to Participant	
Street Address			
City, State, Zip			
Home Phone (include area code)		Mobile Phone	
Name of Individual(s) (other than parent/guardian) permitted to take the participant from camp		Name of Individual(s) (other than parent/guardian) NOT permitted to take the participant from camp	

Health Information

1. Are there any activities or types of activities that the Participant should not participate in (circle)? YES NO
   a. If YES, please explain:
   ____
   ____
   ____

2. In order to participate, a physician or nurse practitioner must have examined the Participant in the last 24 months. A copy of a physical (including one done for participation in school sports) done in the last 24 months may be attached. Otherwise, a physician or nurse practitioner must complete and sign page 3 of this form.

3. Please list any communicable diseases, serious illness, or operations the Participant has or has had in the past. If extra space is needed, please attach additional sheets.

Surgery/Illness	Dates of Surgery/Dates of Illness	Currently being treated? Yes or No

4. Does the Participant have any medical allergies or drug reactions (circle)? YES NO
   a. If YES, please list:

____

____

5. Does the Participant require medication or have special dietary needs (circle)? YES NO
   a. If YES, please list:

Medication or Dietary Need	Dosage	Frequency

*Please Note: Medications listed here MUST be current at the time of the event (any changes/additions must be covered under doctor orders sent with the Participant to the event) and MUST be sent in their original container (anything not sent in the original container will not be dispensed).

6. Please complete the following immunization record. List if immunization has been taken and date received.

Immunization	YES/NO	Date	Immunization	YES/NO	Date
Tetanus			Hepatitis A		
Pertussis			Hepatitis B		
Diphtheria			Hepatitis C		
Measles/mumps/rubella			Meningitis		
Polio			Influenza		
Chicken Pox			Other (i.e., HIB)		

I, the undersigned, (parent or guardian if Participant is under 18) attest that the information provided herein is accurate and complete to the best of my knowledge. I accept legal and financial responsibility for: a) any material misrepresentation included herein and b) any expenses incurred related to participation in Camp Christian listed above including medical expenses. I give permission for the above named "Adult Leader from Church" or any Camp Christian staff member to transport me / my child to and from camp and/or during camp as necessary and understand that the release and indemnification provided in the document referenced below extends to transportation of me / my child.

I acknowledge that by signing this document, I understand that the content of that document is intended to provide: a) authorization for the adult leader from the church listed above to seek medical treatment for me (or my child) in the event I cannot give consent, b) indemnification for Camp Christian from liability related to damages or injuries of any kind sustained because of participation in this event, and c) discretion for the director of camp to remove me (or my child) from camp if in their opinion my/his/her presence poses a threat to myself/himself/herself or anyone else at camp. I understand and consent that the Participant will share a sleeping room – but not a bed – with 1 or more members of the same sex and that in some cases the same room may have both adults and students staying in it.

_______________________________ _______________

Signature of Responsible Party Date

(Parent/Guardian if Participant is under 18, Participant if 18 or over)

____

Printed Name of Individual Signed Above

Physician's Verification

(The following must be completed by a licensed physician or a qualified, licensed nurse practitioner.)

I certify that I have reviewed the health history and examined this Participant listed below and find no contradictions for participation in Camp Christian. This Participant (with noted restrictions):

Participant Name: _

	YES	NO
Does Participant have a medical condition such as sickle cell or respiratory or other ailment or condition which would prevent participation at camps with an altitude of 7–14,000 feet?		
Does the Participant have a medical condition which would prevent participation in our conference?		
If yes, describe condition:		
The Participant is authorized to carry an inhaler, epi pen and other emergency medications with them at all times?		
Has the Participant had seizures in the last year?		
Does the Participant have poorly controlled diabetes?		
Does the Participant have any uncontrolled psychiatric disorders?		

Height	
Weight	
Blood Pressure	

Physician's Name			
Street Address			
City, State, Zip			
Office Phone Number		Office Fax Number	

PHYSICIAN'S SIGNATURE

I have examined the Participant within the past 24 months.

(Check one of the following)

The Participant does not require medication of any kind.

The list of medications on the previous page is current and accurate.

I have indicated new/additional/replacement medications/dosages for the Participant below.

______________________________ ______________

Signature of Physician Date

Medication Needs (that differ from previous page)	New/Add'l/Replacement	Dosage	Frequency