



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 _____

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 ALL 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, as parent or legal guardian on behalf of the person herein named, accept the conditions stated, including the release of the WPAUMC, 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 _____