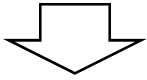


FOR  
OFFICE USE  
ONLY



# Board of Outdoor and Retreat Ministries, Inc. (BORM)

## HEALTH HISTORY FORM

For Children, Youth and Adults



The information in this form is to assist your camp staff in identifying appropriate care. The parent/ guardian should fill out pages 1-3. Any changes to this form should be provided to the camp health officer upon arrival at camp. This form may be photocopied for your convenience.

Name \_\_\_\_\_ Session: 1 2 3 4 5 6 7 8 Program: \_\_\_\_\_  
Last First Cabin: \_\_\_\_\_ Year 200 \_\_\_\_\_

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Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age at Camp \_\_\_\_\_  
Last First Middle

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Address

Home Phone \_\_\_\_\_ Email \_\_\_\_\_ Gender Male Female  
(Circle one)

Custodial Parent/Guardian Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

Home Phone (if different than above) \_\_\_\_\_

Home Address \_\_\_\_\_  
(If different) Address City State Zip

Work Address \_\_\_\_\_ Business Phone \_\_\_\_\_  
Address

Second Parent/Guardian or emergency contact name \_\_\_\_\_  
Last First

Home Address \_\_\_\_\_  
(If different) Street Address City State Zip

Work Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

If above not available in an emergency, notify: Name \_\_\_\_\_  
Relationship \_\_\_\_\_ Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

### Signatures required for attendance

**Parent/Guardian Authorization:** This health form is correct as far as I know and the person herein described has permission to engage in all camp activities except as noted on the back of this form.

**Health Care:** I give the camp health officer permission to give me/my child over-the-counter and prescription medications in accordance with the standing orders approved by the camp physician.

**Permission to Treat:** I hereby give permission to the medical personnel selected by the Camp Director to provide routine health care, to administer medications and to order X-rays, routine tests and treatment for me/my child, and in the event I cannot be reached in an emergency, I hereby give permission to the medical personnel selected by the Camp Director to hospitalize, secure proper treatment, review my/my child's medical records, discuss my/my child's conditions with any medical personnel, and to order injection and anesthesia and/or surgery for me/my child as named above. This form may be photocopied for use out of the camp. This form is a HIPAA authorization release.

**Transportation Authorization:** I give permission for me/my child to be transported in private vehicle if necessary.

**Additional Release:** I release all photos, videos and audio tapes of me/my child to BORM to be used for promotional purposes. I acknowledge that post-camp meetings, reunions, and voluntary events are not conducted under the supervision or auspices/sponsorship of the BORM, which is not responsible for anyone's well-being at such events.

Signature of parent/guardian or adult participant \_\_\_\_\_ Date \_\_\_\_\_  
Printed name \_\_\_\_\_

**Camper Signature:** I agree to abide by any restrictions placed on my participation in camp activities by my physician, parents/guardian or as written herein \_\_\_\_\_  
Date \_\_\_\_\_

## HEALTH HISTORY

The following information must be filled in by the parent/guardian, or adult camper .

### ALLERGIES

List all known

Reaction and management of reaction

Medication allergies \_\_\_\_\_

(Penicillin etc) \_\_\_\_\_

Food allergies \_\_\_\_\_

Other allergies \_\_\_\_\_

Dietary Restrictions \_\_\_\_\_

### MEDICATIONS

Please check here if this person takes no medications on a regular basis.

Please list all medications taken on a regular basis. Prescription medication must be brought in original container. The dosage/frequency schedule identified by the physician will be administered by camp health officer. Please bring enough medication to last the entire camp session. It is not recommended that extra medication be brought to camp. **Please list all prescribed and over-the-counter medications the camper/adult will bring with him/her to camp.** Please leave gray area blank for camp health officer's notes.

Medication	Dosage	Specific time	Reason for taking (Must be stated)
#1.			
#2.			
#3.			
#4			
#5			
#6			
#7			

Additional notes:

**Primary Physician Name** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**Dentist Name & Number** \_\_\_\_\_ **Phone #** \_\_\_\_\_

#### Insurance Information:

**Is the above named covered by family medical /hospital insurance? Yes No**

**Carrier /plan name** \_\_\_\_\_ **Policy or group number** \_\_\_\_\_

**Please attach a copy of your insurance card.**

Explain any dietary or activity restrictions that apply to the above named \_\_\_\_\_

Describe any camp activities from which the camper/staff should be exempted for health reasons. \_\_\_\_\_

<b>Medical History Questions</b>	<b>Circle Yes No</b>	<b>Questions</b>	<b>Circle Yes No</b>
Has had a recent injury, illness or infectious disease	Y N	Has had mononucleosis in the past 12 months	Y N
Has chronic or recurring illness/condition	Y N	Has ever had emotional difficulties for which professional help was sought	Y N
Has autism **	Y N	Has ever had an eating disorder	Y N
Has ADD OR ADHD **	Y N	Wears glasses ,contacts, or protective eye wear	Y N
Has diabetes	Y N	Has a history of sleep walking	Y N
Has asthma	Y N	Has a history of bed wetting	Y N
Has an eating disorder	Y N	If female, has abnormal menstrual history	Y N
Has ever had a seizure	Y N	Uses a wheelchair or walker **	Y N
Has heart defect/disease	Y N	Has a bleeding/clotting disorder	Y N
<p>If ** is indicated, please contact the director of the camper's camp a minimum of 3 weeks prior to the session to assist us with our staff/ volunteer and cabin assignments .</p> <p><b>Please assist us so we can provide the best camping experience for your child!</b></p>			

Please explain all questions to which you answered yes and/or describe any other past, current or on-going medical treatment to on the space provided below.

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### Immunization History

	Date first completed	Most recent booster
<b>DPT</b> (Diphtheria, Pertussis, Tetanus)	_____	_____
<b>Polio</b>	_____	_____
<b>MMR</b> (Measles, Mumps, Rubella)	_____	_____
<b>Hepatitis B</b>	_____	_____
<b>TB Test</b> (most recent)	_____	_____
<b>Tetanus Shot</b> (most recent)	_____	_____

Describe any current physical mental, or psychological conditions requiring medication, treatment, or special restrictions or considerations while at camp. \_\_\_\_\_

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Describe any physical condition requiring restriction(s) on participation in the camp program and a description of that restriction. \_\_\_\_\_

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**FOR CAMP PERSONNEL ONLY**

Arrival Day Check-In

1. Is the emergency authorization on page one of this form signed? **Yes No**
2. Have you been exposed to any contagious disease in the last two weeks? **Yes No** If yes, please explain
3. Have you ever been stung by a bee? **Yes No** If yes, did you have a normal or serious reaction? **Normal Serious**  
If serious, please explain. \_\_\_\_\_
4. Did you bring any ( over-the-counter or prescription) medications with you to camp? **Yes No**  
Is an additional medication form needed to list additional meds? **Yes No** ( The Health Officer will need to record all medications brought to camp.)
5. Is there any other medical/ social/ physical condition of which camp should be informed? **Yes No** If yes, please explain.

Explanations \_\_\_\_\_

\_\_\_\_\_

**Staff member's initial** \_\_\_\_\_

**Information Received from:** Mother Father Grandparent Camper Other \_\_\_\_\_

Date, if different than registration date \_\_\_\_\_