Bliss Summit Bible Camp Health Form

- Page 1 to be completed by parent or staff person if over 18
- Page 2 to be **completed and signed** by Licensed Medical Personnel
- Exception: Immunization History may be completed by Parent or Physician's Office.

Staff Name: ______________________________ Age_______ Sex _____ Birth M/D/Y ____________ Years at Camp _______

If under 18

Parent or Guardian:____ Home Phone (_______)_________________________

Home Address____

Street Number City State Zip code

Alternate Emergency Contact: ______________________________ Relationship _____________________Phone (____)__________

ALLERGIES:

_______Asthma
_______Hay Fever
_______Poison Ivy
_______Insect Stings
______Severe (stops breathing)
______Mild (swollen/rash)
_______Foods_______________________
_______Drugs_______________________
____
_______Other (notes)__________________

HEALTH HISTORY
(Giving approximate dates)

________Frequent ear infections
________Heart Defect/Disease
________Convulsions
________Diabetes
________Bleeding/Clotting Disorders
________Hypertension
________Psychiatric Treatment
________Mononucleosis

________Chicken Pox
________Measles
________German Measles
________Mumps
________Other _______________

IMMUNIZATION HISTORY

This record must be completed as a requirement of the New York State Department of Health for admission to camp. Please record the date (month and year) of basic immunizations and most recent booster doses. Required immunizations must be determined locally. We require all the same information as your local school district.

Vaccine (circle one)	Dates Given	Vaccine	Dates Given
DPT – DtaP – DT		MMR	
DPT – DtaP – DT		MMR	
DPT – DtaP – DT		Hepatitis B	
DPT – DtaP – DT		Hepatitis B	
DPT – DtaP – DT		Hepatitis B	
Polio		Hib b	
Polio		Varicella (Chicken Pox)	
Polio		Tuberculin Test	
Polio		Results – (circle one)	neg. pos
Polio		Other	

Does this person have a disability or chronic recurring illness? ____

Are there any dietary modifications?____

Name of Family Physician and/or Health Clinic ____ Phone (______)_______________

Do you carry family medical/hospital insurance? If so, indicate carrier ______________________Policy/Group No._____________

Please attach a photocopy of both sides of your insurance card.

Important- Must be completed for attendance

To my knowledge, this health history is correct and complete. The person herein described has permission to engage in all camp activities except as noted. I give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I also give permission to the physician selected by the camp to secure and administer treatment, including hospitalization for the person named above.

____ Date_______________________________

Parent Signature

I understand and agree to abide by the restrictions placed on my camp activities as noted on this health form.

____ Date _______________________________

Staff Signature

The following section must be signed and completed by Licensed Medical Personnel

Individualized orders for: Name:_________________________________ DOB___________ Height________Weight_______

Standard Over the Counter/PRN Medications (The following medications are available in the infirmary and will be administered at the discretion of medical staff, only if the person's healthcare provider indicates approval.)

Medication	Administer order	Route	Dose/Time
Tylenol	Yes No	PO	
Advil	Yes No	PO	
Midol	Yes No	PO	
Tums	Yes No	PO	
Pepto Bismol	Yes No	PO	
Kaopectate	Yes No	PO	
Sudafed	Yes No	PO	
Benadryl	Yes No	PO	

HCP Name_______________________
Phone No. (____)_________________
License No.______________________
Signature________________________
Date____________________________
Physician's notes regarding this camper:__________________________
____
____

Prescription Medications (Please complete with person's current regimen of scheduled medications, including inhalers. Use 2nd page if needed.) All medications sent to camp must be in their original containers. No pill boxes or unlabeled containers will be accepted.

Medication	Route	Dose	Time(s)	Diagnosis

All medications sent to camp must be in their original containers. Medications in pillboxes or other containers will not be accepted.

For Inhalers:
Has staff been trained in proper use of the inhaler? Yes No
Parental consent for staff to keep inhaler Yes No ____
Signature of parent/guardian

Bliss Summit Bible Camp is not responsible for inhalers lost while in staff's possession.

Thank you.