

# Bliss Summit Bible Camp Health Form

Updated 2022

**Campers will not be allowed to attend camp unless we have a completed Health form**

Page 1 must be completed by parent or staff person if over 18

Camper Name: \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Birthdate \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Home Address \_\_\_\_\_  
Street Number City State Zip code

Alternate Emergency Contact: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

<u>ALLERGIES</u>	<u>HEALTH HISTORY</u>
<input type="checkbox"/> Asthma <input type="checkbox"/> Hay Fever <input type="checkbox"/> Poison Ivy <input type="checkbox"/> Insect Sting <ul style="list-style-type: none"> <li><input type="checkbox"/> Severe (stops breathing)</li> <li><input type="checkbox"/> Mild (Swollen/rash)</li> </ul> Foods: _____ Drugs: _____ Other: _____	<input type="checkbox"/> Frequent ear infections <input type="checkbox"/> Heart Defect/Disease <input type="checkbox"/> Seizures <input type="checkbox"/> Diabetes <input type="checkbox"/> Bleeding/Clotting Disorders <input type="checkbox"/> Hypertension <input type="checkbox"/> Tachycardia <input type="checkbox"/> Psychiatric Treatment
Does this Camper have any disability or reoccurring illness?	Does this camper have any dietary modifications?

<b>IMMUNIZATIONS HISTORY</b>			
<p><b>This form must be completed as a requirement if the New York State Department of Health for admission to camp.</b> Please record the date, month 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</p>			
Vaccine	Date	Vaccine	Date
DPT-DtaP_DT		Hep B	
DPT-DtaP_DT		Hep B	
DPT-DtaP_DT		Hep B	
MMR		HibB	
MMR		Varicella (chicken pox)	
Polio		Other	

**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, including wilderness swimming, 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 names above.

\_\_\_\_\_  
Parent Signature Date \_\_\_\_\_

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

\_\_\_\_\_  
 Date \_\_\_\_\_

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

Individualized orders for

Name: \_\_\_\_\_ DOB \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Medication	Administration Order	Route	Dose	Frequency
Tylenol	Yes/No	PO		
Advil	Yes/No	PO		
Benadryl	Yes/No	PO		
Tums	Yes/No	PO		
Pepto Bismol	Yes/No	PO		
Midol	Yes/No	PO		
Kaopectate	Yes/No	PO		

HPC Name:
Phone #:
License #:
Signature:
Date:
Physicians Notes Regarding Camper:

**Standard Over the Counter/PRN Medications:** The previous medications are available in the infirmary and will be administered at the discretion of camp medical staff, only if the camper's POC has approved list above, and signed form above.

**Prescription Medications:** Please complete with camper's current regimen of scheduled medications, including inhalers. All medications sent to camp must be in their original containers. No pill boxes or unlabeled containers will be accepted. Camp medical staff can only administer scheduled meds if camper's POC has approved list and signed form above.

Medication Name	Dosage	Route	Time/Frequency <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime If PRN: every _____ hrs	Reason for Taking	Side Effects
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