Bliss Summit Bible Camp Health Form

Updated 2025

Campers will **NOT** be allowed to attend camp unless we have a completed Health form **including the Dr. signature on the back side of this form**
This is required of all resident camps in the state of New York – completed forms may be faxed to 585-672-9016 or mailed to Bliss Summit 6113 Horton Road Bliss, NY 14024
Page 1 must be completed by parent or staff person if over 18

Camper Name: _____Age by camp_____ Gender at birth _____ Birthdate _____

Parents or Legal Guardians: _____Camp Week Attending _____
Please list both parents or guardians
Parent Phone #1: (_____)_____ Parent Phone #2: (_____)_____

Camper's Home Address

_____
Street Number City State Zip code

Alternate Emergency Contact: _____ Relationship _____Phone (____) _____

ALLERGIES	**HEALTH HISTORY**
___Asthma ___Hay Fever ___Poison Ivy ___Insect Sting • Severe (stops breathing) • Mild (Swollen/rash) ___ Foods: _____ ___ Drugs: _____ ___ Other: _____	___ Frequent ear infections ___ Heart Defect/Disease ___ Seizures ___ Diabetes ___ Bleeding/Clotting Disorders ___ Hypertension ___ Tachycardia ___ Psychiatric Treatment
Does this Camper have any disability or reoccurring illness?	Does this camper have any dietary modifications?

IMMUNIZATIONS HISTORY

This form must be completed as a requirement if the New York State Department of Health for admission to camp. 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

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.

_____ Date_____
Parent Signature

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 completed and SIGNED by Licensed Medical Personnel in order for your camper to attend their camp week.

Name:_____ DOB _____ Height _____ Weight_____

Standard Over the Counter/PRN Medications				
Medication (circle one if necessary)	Administration Order	Route	Dose	Frequency
Tylenol/Advil	Yes/No	PO		
Cough Drops	Yes/No	PO		
Benadryl/ Sudafed	Yes/No	PO		
Tums	Yes/No	PO		
Other _____	Yes/No	PO		
Other _____	Yes/No	PO		
Other _____	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 formed above. ***Any additional OTC medications the camper may need (including vitamins) MUST be listed above by the POC and provided by the parent.***

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 ___ Breakfast ___ Lunch ___ Dinner ___ Bedtime If PRN: every _____ hrs	Reason for Taking	Side Effects
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