Health History Form
Warren W. Willis United Methodist Camp

Please fill this form out completely, sign it, and have it notarized prior to your arrival at camp. We recommend that you consult with your family physician when completing this form as necessary.
Bring this form with you to Summer Camp registration, where it will be reviewed by our Health Care Staff.
Attach additional pages if needed.

Week of Camp Attending ___________________

Circle One:
Elementary School Middle School High School
Creative Spirit Trip Camp

Camper Information:

Camper's Name: ______________________________________ Gender: ☐ M ☐ F

Social Security #: ______________________________________

Birthdate: _____/ _____/ _____ Age at time of camp: _____ Grade in Fall 2009: ____________

Mailing Address: __________________________ City: _______________ State: ________ Zip: _________

Mother/Guardian Name(s): ____

Home Phone: (__)_______________Work Phone: (__)_______________ Cell Phone: (__)__________________

Father/Guardian Name(s): ____

Home Phone: (__)_______________Work Phone: (__)_______________ Cell Phone: (__)__________________

If parent is not available in an emergency, notify: ___________________________________

Address: __________________________ City: _______________ State: ________ Zip: _________

Home Phone: (__)_______________Work Phone: (__)_______________ Cell Phone: (__)____________

Does camper have any known allergies? ☐ Yes ☐ No

Allergies to Medications: ____

Food Allergies: ____

Other Allergies (environment, allergies, etc.): ____

List any dietary restrictions: ____

☐ I have reviewed the programs and activities of the camp and feel that the camper can participate without restrictions.

☐ I have reviewed the programs and activities of the camp and feel that the camper can participate with the following restrictions or limitations:

____

____

Health History: (check any that apply)

☐ Epilepsy or seizures ☐ Frequent ear infections ☐ Menstrual problems ☐ Asthma
☐ Frequent sore throats ☐ Headaches ☐ Bed-wetting ☐ Heart Disease
☐ Back pain or strain ☐ Alcohol/drug addiction ☐ Attention deficit disorder ☐ Diabetes
☐ Recent hospitalization ☐ Recent Surgeries ☐ Recurrent/chronic illness ☐ Recent injury
☐ Recent infectious disease ☐ Wears glasses/contacts ☐ Fainting or dizziness ☐ Skin problems
☐ Passed out/chest pain during exercise ☐ Had "mono" in the past 12 months ☐ Problems falling asleep/sleepwalking
☐ Problems with diarrhea/constipation ☐ Other: ____

Pertinent past medical treatment: ____

Is camper current on all immunizations needed for school? ☐ Yes ☐ No

If your camper has not been fully immunized, please sign the following statement: ***I understand and accept the risks to my child from not being fully immunized*** ______________________________

Date of last Tetanus shot: _______________Blood Type (if known) _______________

Does the camper have a health condition (e.g. allergies, chronic conditions) or special circumstances which may affect program participation, special housing need, or anything we ought to know prior to emergency treatment?☐ Yes☐ No
If yes, please explain: ____
____
____

Please describe any current physical, mental, or psychological conditions requiring medication, treatment, or special restrictions or considerations while at camp: ______________________________
____
____

Family Medical Insurance: ☐ Yes☐ No Name of Insured: ________________Carrier: ____________________
Group # ___________________ Policy # ___________________
Name of Family Physician: ______________________________ Phone: (___)_______________________

Parent/Guardian Authorization:

My child has permission to take part in all camp activities under supervision unless limitations are noted above, and I agree that the camp or camp personnel will not be held responsible for accidents arising there from. I hereby give my 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 my child. In the event that I cannot be reached in an emergency, I hereby give my permission to the physician selected by the camp to secure and administer treatment, including hospitalization, injection, surgery, and anesthesia for the person named above. This completed health form may be photocopied for trips out of camp.

Signature of Parent/Guardian ____________________________ Date: __________________________

Permission to Administer Medications:

I, the parent/guardian of _________________________give my permission to the camp Heath Care Provider or his/her designate to give the following medications (or the generic equivalents) to my child, in accordance with the recommended package dosing for the specific indications below. These medications are available at camp and need not be brought by participants.

	Yes	No		Yes	No
Tylenol: Mild fever or discomforts	☐	☐	Benadryl: Allergy symptoms	☐	☐
Ibuprofen: Mild fever or discomforts	☐	☐	Sudafed: Allergy Symptoms	☐	☐
Throat Lozenges: Coughs/sore throat	☐	☐	Antacid: Upset Stomach	☐	☐
Topical Creams: Itching, sunburn, or	☐	☐	Anti-diarrheal: For diarrhea	☐	☐
Insect bites			Sore throat spray	☐	☐
Permission to follow recommendations	☐	☐	Lice Shampoo and Cream	☐	☐
By local Poison Control Centers			Robitussin DM	☐	☐
Antibiotic Cream	☐	☐	Aloe	☐	☐
Pepto-Bismol	☐	☐			

Signature of Parent/Guardian: ____________________________Date: __________________________

Note: The camp personnel will notify you if your child displays the following symptoms:

- Any illness that persists longer than 24 hours; including fevers, coughs, excess expulsion of bodily fluids, allergic reactions, severe tiredness.
- Any injury that causes severe prolonged pain, discolorization and/or swelling.
- Any condition that cannot be sufficiently treated by camp personnel.
- Any condition requiring transport to other medical services.

TO BE COMPLETED BY A NOTARY PUBLIC
State of Florida, County of ___________________
The forgoing instrument was acknowledged before me this __________ day of _____ 20_________
by (print name)____________________________who is personally known to me, or has produced
(type of identification)_________________________ as identification and did not take an oath.
Notary Public (signature):____
Name of Notary printed: My Commission expires: __________________________
My Commission number is: (Notary Seal/Stamp)