

Name _____
For Camp Use

Staff/Camper
(Circle one)

Dorm _____
For Camp Use

Year _____
For Camp Use

Health History and Examination Form for *United Youth Camps*

Sponsored by:
United Church of God, an International Association

This form must be completed (all 5 pages) by each person attending camp, or in the case of minors, by their parents or guardians. PLEASE PRINT.

PERSONAL INFORMATION

Applicant's Name: _____ Sex: Male Female Birth Date: ____/____/____.
First Middle Last

Address: _____ Phone: (____) _____
Street Address City State Zip

Social Security Number of Participant: _____ - _____ - _____

Parent/Guardian or Emergency Contact: _____ Relationship: _____

Telephone: (____) _____ (____) _____ (____) _____
Home Work Other

Second Parent/Guardian/Emergency Contact: _____ Relationship: _____

Telephone: (____) _____ (____) _____ (____) _____
Home Work Other

INSURANCE INFORMATION

Please furnish the following medical and insurance coverage information:

Insurance Company: _____ Policy or Group # _____

Social Security Number of Policyholder or Insurance ID Number: _____ Policyholder Date of Birth: _____

Insurance Phone # (____) _____ Address: _____

Family Physician: _____ Phone: (____) _____

Address: _____

Family Dentist/Orthodontist: _____ Phone: (____) _____

Address: _____

MEDICAL HISTORY

Many activities such as sports and challenge courses require participating in physical exercises that are physically demanding. Do you have health problems or disabilities that might hinder you from participating fully in camp activities? Yes No

If yes, please describe in detail (attach note if necessary): _____

Do you have any severe allergies (including food allergies) or any other condition or limitation that could affect your camp experience?

Yes No If yes, please explain (attach note if necessary): _____

Are you allergic or sensitive to any medicines or other substances? Yes No If yes, please list and describe the reaction and its management: _____

Medications Being Taken

Are you taking any medications (including over-the-counter or other nonprescription drugs) routinely? Yes No

If yes, please list all medications (including over-the-counter or other nonprescription drugs) taken routinely. Be sure to bring your medication with you in the original packaging that will identify the doctor, the dosage and the frequency of administration:

Medication	Dosage	Frequency	Reason for Taking

Health History – Explain any “yes” answers below

Has/does the participant:	YES	NO		YES	NO
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have an orthodontic appliance being brought to camp?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?.....	<input type="checkbox"/>	<input type="checkbox"/>	14. Have any skin problems (e.g., itching, rash, acne)?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	15. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
4. Wear glasses, contacts or protective eye wear?... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
5. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	17. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever passed out during or after exercise?..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have a current history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
8. Ever had seizures?..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	20. Have an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had chest pain during or after exercise?..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21. Ever had emotional or mental difficulties for which professional help was sought?..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>			
11. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>			
12. Ever had back problems?..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

If you checked “yes” to any of the above, please note the question number and explain.

Which of the following has the applicant had? (Check each one that applies)

- Measles Chicken Pox German Measles Mumps Rheumatic Fever
 Hepatitis A Hepatitis B Hepatitis C TB Test (Date: _____, Pos or Neg? _____)

Immunizations – Fill in the dates for any of the following immunizations applicant has had.

Immunization	Date Last Received	Immunization	Date Last Received
DPT		Mumps	
TD (tetanus/diphtheria)		Rubella	
Tetanus		Gamma Globulin (Hepatitis)	
Polio		Chicken Pox	
German Measles		Smallpox	

NOTE: A record of immunizations is for informational purposes. Immunizations are not a required prerequisite for acceptance to or attendance at camp. If a camper has not been immunized, however, and one of the above-named communicable or contagious diseases is found in camp, he or she will be subject to the regular quarantine or isolation procedures of the camp and of the community for children who are not immune.

ADULT APPLICANT: I certify that to the best of my knowledge this health history is correct and complete, that I am in good health and able to participate in this event/assignment.

Adult applicant signature _____ Date _____

PARENT/GUARDIAN AUTHORIZATION:

This health history is correct and complete as far as I know and the person herein described has permission to engage in all camp activities except as noted. I understand that if any statement in this Health History is false, misleading or incorrect, or the Church is unable, in its sole judgment, to properly care for or protect my child (due to his/her medical condition), he or she may be sent home at my expense.

Parent signature _____ Printed Name _____ Date _____

PARENTAL NOTIFICATION POLICY:

United Youth Camps policy is that parents will be contacted 1) anytime the nurse or a physician deems necessary; 2) anytime a camper is taken to see a physician, dentist or emergency personnel for an accident or illness; 3) when an illness lasts longer than 24 hours.


IMPORTANT – These boxes must be completed for attendance

Permission to Provide Necessary Treatment or Emergency Care:

I hereby give permission to the available medical personnel at the camp to administer prescribed medications and provide routine health care, including over-the-counter medications, to my child as deemed necessary by the UYC medical staff. In the event of an accident/illness, I consent to the administration of emergency on-site first aid by trained personnel. If I cannot be reached in an emergency, I hereby give permission to the camp medical personnel to secure and administer treatment, including hospitalization, for the person named above. This authorization includes consent to any medical, emergency dental, surgical, chiropractic or hospital diagnosis, treatment or care to be rendered to or for me/or my child under the general or specific supervision of a qualified physician, surgeon, chiropractor or dentist. It also includes permission to release any records necessary for supervision, treatment, referral, billing or insurance purposes and to provide or arrange necessary related transportation. I understand and agree that the foregoing will be at my expense. This consent shall terminate without further notice on the date when a minor reaches 18 years of age. This completed form may be photocopied for trips out of camp.

Parent/guardian (or adult camper/staff) signature _____

Printed Name _____ Date _____

 **If medication for life-threatening conditions is brought to camp (epi pen, inhaler, etc.)** I hereby request that said medication remain with: UYC Personnel My Child **(Please check one.)**

I understand that accommodating some medical conditions or disabilities may not be ideal and may differ depending on the activity. Therefore, if I am accepted, I agree to abide by any restrictions which may be placed on my camp activities that the camp staff feels are necessary for my comfort or safety or that of my fellow campers or staff.

Camper/Staff signature _____ Date _____

Special note about medication:

Please note that if your camper will be bringing **ANY** medications to camp, including all prescription, over-the-counter and herbal remedies, the following rules will need to be followed:

- 1) All medications must be in their original packages. i.e. prescriptions in the prescription bottle, Tylenol in the Tylenol bottle, herbs in the bottle that they were originally bought in.
- 2) All medications must be accompanied by written and signed instructions for administration (the prescription on the bottle will be fine unless doses or times have changed).
- 3) Any nonprescription bottles must have the camper's name written on them (prescription bottles must be for that camper).

PLEASE help us to take good care of the precious and wonderful campers that you have entrusted to us! – UYC Medical Staff

Personal Medical Insurance

The United Church of God is grateful to those who freely give of their time and expertise to assist in the operation of United Youth Camps (UYC). While we place a significant emphasis on safety at UYC for both staff and campers, accidents may happen and people may get injured. For this reason, we strongly recommend that you carry adequate personal medical insurance. We realize that it is not always affordable. However, paying actual hospital and doctor expenses can easily cost far more. As we review your application, this is an important factor in determining those most suited to serve at UYC.

Supplemental Accident Insurance

We realize that your personal insurance may require you to pay a deductible and co-payments, and possibly other costs. In an effort to help reduce the cost to you personally, the Church has been able to acquire supplemental accident medical coverage for a nominal cost. Though the Church is unable to provide financial assistance beyond what is offered through this insurance, we are happy to include all campers as well as staff volunteers in this coverage, particularly since they are not covered by Workers' Compensation. The extent (amount and period) of accident coverage may vary from year to year. If you are accepted as a camper or approved to serve as a UYC staff member, a copy of the coverage will be supplied upon request.

Release and Waiver

I have read, fully understand, and agree to comply with all the rules and standards of the project and its staff. I understand and agree with its implications and the stated consequences. I also affirm that the information given in this application is true and complete and that I am in good health and able to participate in the expected activities and routine for the project(s) marked on the front. In consideration of being allowed to participate, I hereby release, indemnify, save and hold harmless and covenant not to sue the United Church of God, *an International Association*, its officers, Council of Elders, agents, employees, volunteers and helpers and any other related entity (hereinafter collectively called the "Church") from all actions, claims, demands or suits which are based upon, or result from injuries sustained, arising out of, or in the course of, participation or attendance at camp. This release, however, shall not apply to claims covered by the Church's liability insurance (e.g. for its negligence) , but is applicable to claims not covered by that insurance. *It is strongly recommended that you have your own medical insurance protection* since participants are involved in activities at their own risk.

Signature_____

Date Signed_____

Print Name_____

Parents' Signature(s) also Required for Minors:

I/we have read, fully understand and agree to the foregoing statements.

X _____ Date _____
Father

X _____ Date _____
Mother

MEDICAL EXAM / RECOMMENDATION AND RESTRICTIONS (Exam to be done within 24 months of arrival at camp)

Applicant's Name: _____ Birth Date: ____ / ____ / ____

I have examined the above named participant on ____ / ____ / ____ (date). BP _____ Weight _____ Height _____

In my opinion, the above applicant: is is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions _____

Current treatment at the time of this report includes _____

Recommendations and Restrictions at Camp

Treatment to be continued at camp _____

Medications to be administered at camp (name, dosage, frequency) _____

Any medically-prescribed meal plan or dietary restrictions _____

Known allergies _____

Description of any limitation or restriction on camp activities _____

Additional information for health care staff at the camp _____

Signature of Licensed Medical Personnel _____

Printed name _____ Title _____

Address _____

Phone _____ Date _____