Koinonia Conference Grounds
Camper Health Form

Full Name: ____ Date of Birth: __________________ Age at Camp: _______

Gender: ○Male ○Female Camp Dates:____

The information provided on this form will be used to brief kitchen staff about nutritional needs, educate Cabin Leaders & the Camp Director about camper needs, and provide Healthcare Staff with background about your child. Receiving adequate information at least two weeks prior to your child's arrival is crucial to our ability to provide the proper supportive environment. Please read and complete this form thoroughly.

HEALTH HISTORY: To be completed and signed by parent or guardian. Please keep a copy for your records and to record changes in your child's health status. Please notify Koinonia Conference Grounds in writing if there are any changes.

ALLERGIES: Please mark those that apply to this camper.

○This camper has no known allergies.
○This camper has an allergy to the following: (List all foods, medications, and substances) ______________________________
____

Does this cause anaphylaxis? ○Yes ○No ○Unknown

Please describe allergic reaction (if any) and what steps are taken to manage it (attach additional information if needed): ___________
____
____
____

NUTRITION: We are able to work with some medically prescribed diets but are unable to cater to individual food preferences. Please mark those that apply to this camper. Please call if you have any questions.

○This camper eats a regular, varied diet
○This camper is on a special diet
(Our expectation is that the camper will bring his/her own supply of products (such as Lactaid and gluten-free items) and will contact the camp nurse when the supplement is needed.)

CHRONIC CONCERNS: Please mark all that pertain to this camper and provide information about supportive health care.

○This camper has no chronic health concerns and is capable of full participation in this program.

This camper has the following chronic health concern(s):

○Asthma	○Headaches	○Sleepwalking	○Diabetes
○Hearing Difficulties	○Menstrual Cramps	○Frequent ear infections	○Bedwetting
○Bee Sting Allergy	○Seizure Disorder	○Surgical History	○Fainting
○Fears/Phobias	○Other (please describe):_______________________________________		

Please provide information about supportive health care needed for each marked item (if any):________________________________
____
____

Date of camper's last physical exam: _____/______/__________ (must be within 12 months of camp)

If *Surgical History* is marked above, please explain: Date of Surgery: __________Type of surgery: ______________________________

Are all symptoms resolved? ○Yes ○No - Please explain: ____

Is the camper cleared by parent and physician for active camp participation? ○Yes ○No Date of last Tetanus shot: ___________

Camper's Physician: ____ Office Phone: (_____) ____________________

Camper's Dentist: ____ Office Phone: (_____) ____________________

MEDICATIONS: All medications MUST be in original, pharmacy-provided containers and appropriately labeled. Please attach a note if the camper has been taking current dose for less than three months prior to arrival or if there are any changes.

○This camper does not take any medication.
○This camper takes daily medication:

1. Medication: _______________________________ Reason for Taking: ___________________________________
Dose Taken: ______________________________ How often each day? ____________________________________
2. Medication: _______________________________ Reason for Taking: ___________________________________
Dose Taken: ______________________________ How often each day? ____________________________________
3. Medication: _______________________________ Reason for Taking: ___________________________________
Dose Taken: ______________________________ How often each day? ____________________________________

MEDICATIONS (continued):
The following medications, stocked in the Gauze Pad/Health Center, are used to manage illness or injury and dispensed as directed by our medical protocols. Generic form may be used. Please cross-out any medicine your camper ***should not*** be given:

Acetaminophen (Tylenol)	Chamomile Tea	Guaifenesin/DM (Cough Med)	Kaopectate/Anti-Diarrheals
Aloe	Cough Drops	Hydrocortisone Cream	Nix
Antacid	Decongestants	Ibuprofen (Motrin)	Tinactin
Bismuth liquid/tabs	Diphenhydramine (Benadryl)	Insect Repellant	Triple Antibiotic Cream
Calamine Lotion	Dramamine	Iodine Swabs	

MENTAL, EMOTIONAL AND SOCIAL HEALTH: Please mark YES or NO for each statement.

1. This camper has been diagnosed with ADD or ADHD .... ○Yes ○No
2. This camper has psychiatric diagnosis such as depression, OCD, panic/anxiety disorder .... ○Yes ○No
3. This camper has an emotional health concern .... ○Yes ○No
4. During the past academic year, this camper has seen or is currently seeing a professional to address mental/emotional health concerns. .... ○Yes ○No
   If yes, please specify: ____
5. This camper has had a significant life event that continues to affect the camper's life .... ○Yes ○No
   If yes, please provide written information about the event.

WHAT HAVE WE FORGOTTEN TO ASK? Please provide additional information about your child's health which may have been neglected on this form. We are particularly interested in information which has impact upon your child's ability to fully participate in our active camp program.

BILLING INFORMATION FOR HEALTH CARE: Parents/Guardians are financially responsible for health care given by an out of camp provider. To whom should this provider route charges for your campers health care if the need arises? **Please include a copy of an insurance card**. Please copy both sides of the card so addresses and telephone numbers are readable.

○This camper is not covered under an insurance policy.

○This camper is covered under the following health insurance:

Insurance Company: ________________________________ Policy/Member #: ____________________________________

Insurance Company Telephone: (_______) ____________________ Name of Subscriber: ________________________________

Insurance Company Address: ________________________________ City: ___________________ State: ______ Zip: _________

PARENT CONTACT INFORMATION: We will call in the event of an emergency or if we have questions about your child. Please provide contact information for other people who know your child and with whom we can consult if we cannot reach you. We will assume you have spoken with these individuals and that they are willing to assist, should the need arise.

Custodial Parent/Guardian: ____________________________________ Relationship to Camper: ______________________

Camper Lives With (name): ______________________________________ Daytime Telephone: (_____) __________________

Address: ____ Evening Telephone: (______) _________________

City: _________________________ State: _________ Zip: ____________ Cell Phone: (______) _________________________

Alternate Contact: ____ Telephone: (______) _________________________

Relationship to Camper: ____

Alternate Contact: ____ Telephone: (______) _________________________

Relationship to Camper: ____

PARENT/GUARDIAN CONSENT AND AUTHORIZATION FOR HEALTH CARE: This health history is correct and the camper described has permission to participate in all camp activities, except as noted by me and/or the examining physician. I will not hold Koinonia Conference Grounds or its agents liable for injury caused by common accident, illness, or the rendering of emergency care. I give permission for this child to be transported to and from any offsite locations in emergency situations (if any) by authorized vehicles. Koinonia Conference Grounds has my permission to obtain a copy of my child's health record from the providers who treat my child. I understand that information about my child's health will be shared on a "need to know" basis with other Koinonia Conference Grounds staff. I give permission to the physician selected by Koinonia Conference Grounds to order X-rays, routine tests and treatment for the health of my child. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for my child. This form may be photocopied. By signing below, I give permission to Koinonia Conference Grounds to use video or photography of me or my family members for promotional purposes.

***SIGNATURE OF CUSTODIAL PARENT/GUARDIAN:** ____ **DATE:** __________