

**Health History Form**  
**Children/Youth Campers**  
**Camp & Retreat Ministries**  
**Oregon-Idaho Conference**

This completed form (2 pages) should be sent in to the camp at least 10 days prior to your arrival. Attach additional pages if needed. Any changes to this form should be provided to camp health personnel **in writing** upon participant's arrival in camp.

**Dates of Camp Attendance** \_\_\_\_\_

**Name of Camp or Event** \_\_\_\_\_

**Site:** (Circle one) Latgawa Magruder Suttle Lake  
Sawtooth Wallowa Lake Other

**Mail this form to the Camp Site** (circled above)  
at least 10 days before the first day of the event.

**Camper's Name** \_\_\_\_\_

Birthdate \_\_\_\_\_

Address \_\_\_\_\_

Gender:  Male  Female

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ email \_\_\_\_\_

**Parent/Guardian Name(s):** \_\_\_\_\_

Primary Phone \_\_\_\_\_ Other Phone \_\_\_\_\_ email \_\_\_\_\_

Address (if different) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**If parent not available in emergency, notify:** \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

**DIETARY RESTRICTIONS: Check all that apply.**

No Dietary Restrictions  Vegetarian  Lactose Intolerant

Diabetic  Gluten-Free  Vegan

*Please give us specifics* \_\_\_\_\_

**HEALTH HISTORY: Check all that apply**

Asthma  Diabetes Type 1  Attention Deficit Disorder  Frequent headaches  
 Epilepsy or seizures  Diabetes Type 2  Autism Spectrum  Bed-wetting  
 Frequent sore throats  Frequent ear infections  Menstrual problems

Does the camper have a health condition or special circumstance which may affect program participation housing assignment?

*If yes, please explain:* \_\_\_\_\_

**Is camper presently taking any medications?**  Yes  No (List all med's on second page)

**Does camper have any known allergies?** (Specify): \_\_\_\_\_

If any allergies, does camper use/carry an epi-pen?  Yes  No

Date of Last Tetanus shot (if known) \_\_\_\_\_

**INSURANCE INFORMATION:**

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 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 insurance purposes. I give permission to the camp to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed health form may be photocopied for trips out of camp.

I give permission for my child's photo, oral interview or written material to be used in advertising of the camp or camping program.

**Signature of parent/guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

*Please complete the second page of this form.*

## Permission to Administer Medications

Camp & Retreat Ministries

Camp Latgawa, Camp Magruder, Sawtooth Camp, Suttle Lake Camp & Wallowa Lake Camp

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

**Tylenol:** Mild fever or discomforts  Yes  No

**Ibuprofen:** Mild fever or discomforts  Yes  No

**Throat Lozenges:** Cough/sore throat  Yes  No

**Topical Creams:** Itching, sunburn, or insect bites  Yes  No

**Benadryl:** Allergy symptoms  Yes  No

**Antacid:** Upset stomach  Yes  No

**Anti-diarrheal:** For diarrhea  Yes  No

**Permission to follow recommendations by Oregon Poison Control or Idaho Poison Control.**  Yes  No

**Signature of parent/guardian:** \_\_\_\_\_ **Date** \_\_\_\_\_

*Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.*

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

*Attach additional page for more medications.*

**All medications brought to camp must be in the original containers.**

**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.

### **Upon camper check-in:**

Health History Form Verified \_\_\_\_\_ by \_\_\_\_\_  
*Date* \_\_\_\_\_ *Initials* \_\_\_\_\_.

Health History Form Updated \_\_\_\_\_ by \_\_\_\_\_  
*Date* \_\_\_\_\_ *Initials* \_\_\_\_\_.