

**Camper's full printed name** \_\_\_\_\_ preferred name \_\_\_\_\_  
Camper's gender \_\_\_\_\_ Weight \_\_\_\_\_ Age while at camp \_\_\_\_\_ Birthdate \_\_\_\_\_  
Circle camper's church group affiliation: Akron Canton Cleveland Columbus Other: \_\_\_\_\_

**ALL CAMPERS: PLEASE BRING CLOSE-TOED SHOES AND SOCKS TO CAMP WITH YOU!**

**All sections requiring signatures must be completed.**

Check here if the camper has no health insurance coverage.

Please PRINT the following: Parent/guardian name: \_\_\_\_\_  
Your Email \_\_\_\_\_ Your Phone \_\_\_\_\_  voice  text  
Your alternate phone \_\_\_\_\_  voice  text  cell Other contact name/number \_\_\_\_\_  
Insurance company name \_\_\_\_\_ Policy number \_\_\_\_\_  
Ins. phone numbers (general) \_\_\_\_\_ (precertification) \_\_\_\_\_  
Policy holder name \_\_\_\_\_ Address \_\_\_\_\_  
Doctor's name and phone # \_\_\_\_\_  
Dentist's/orthodontist's names and phone #s \_\_\_\_\_  
Other physicians' contact information \_\_\_\_\_

Please copy both sides of insurance cards that cover the camper and attach to this form. (Do not send originals.)

Mark "yes" or "no" to each category below and complete each space as applicable. All spaces must be complete.

**Identify dates of current immunizations below (\* items MUST be current):**

YES	NO	MONTH and YEAR of immunization
<input type="checkbox"/>	<input type="checkbox"/>	_____ Polio (TOPV or e-IPV)*
<input type="checkbox"/>	<input type="checkbox"/>	_____ Measles, Mumps & Rubella (MMR)*
<input type="checkbox"/>	<input type="checkbox"/>	_____ Diphtheria, Tetanus & Pertussis (DTaP or TdaP)*
<input type="checkbox"/>	<input type="checkbox"/>	_____ Varicella (immunized or had chicken pox)
<input type="checkbox"/>	<input type="checkbox"/>	_____ Tetanus Booster (dT or TdaP)* – if over 10 years since last dose
<input type="checkbox"/>	<input type="checkbox"/>	_____ Tuberculin screen
<input type="checkbox"/>	<input type="checkbox"/>	_____ Hepatitis B (if born after 1/1/92)
<input type="checkbox"/>	<input type="checkbox"/>	_____ Other, identify: _____

If your camper is not fully immunized, please sign the following: I understand and accept the risks to my child for lacking full immunization. Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

**For the health and safety of all campers, PLEASE DO NOT SEND YOUR CHILD TO CAMP IF SHE/HE IS in a CONTAGIOUS phase of ANY ILLNESS or parasites such as (but not limited to) MEASLES, CONJUNCTIVITIS ("Pink Eye"), PEDICULOSIS (Lice), INFLUENZA, etc.**

**Also, to protect against disease, please bring shoes that your child can wear into the showers.**

**Does the camper have any allergies/severe reactions to...**

YES	NO		YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Environment	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/migraines
<input type="checkbox"/>	<input type="checkbox"/>	Bee stings	<input type="checkbox"/>	<input type="checkbox"/>	Poison Ivy	<input type="checkbox"/>	<input type="checkbox"/>	Nuts or peanuts
<input type="checkbox"/>	<input type="checkbox"/>	Medications (list, and describe response): _____						
<input type="checkbox"/>	<input type="checkbox"/>	Other foods (explain): _____						
<input type="checkbox"/>	<input type="checkbox"/>	Other (explain): _____						

**Does the camper have any of the following special or activity-limiting conditions?**

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Physical condition/limitation/restrictions	<input type="checkbox"/>	<input type="checkbox"/>	Sleep walking
<input type="checkbox"/>	<input type="checkbox"/>	Mental condition/limitation	<input type="checkbox"/>	<input type="checkbox"/>	Talk in sleep
<input type="checkbox"/>	<input type="checkbox"/>	Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	Nightmares
<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD etc.	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia
<input type="checkbox"/>	<input type="checkbox"/>	Enuresis (bedwetting)	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Back/joint problems
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Epistaxis (nosebleeds)
<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or fainting
<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic device	<input type="checkbox"/>	<input type="checkbox"/>	Whooping cough
<input type="checkbox"/>	<input type="checkbox"/>	CI, hearing aids	<input type="checkbox"/>	<input type="checkbox"/>	Protective eyewear, glasses or contact lenses
<input type="checkbox"/>	<input type="checkbox"/>	Other (describe _____)			

Explain any "YES" marks above, and add any information of which the nurse/counselor/leader/camp staff should be aware:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The above information is true to the best of my knowledge.

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

**\*\*CONFIDENTIAL\*\***

**Camper's name** \_\_\_\_\_ **Age while at camp** \_\_\_\_\_ **Birthdate** \_\_\_\_\_  
**Camper's weight** \_\_\_\_\_ **Church group affiliation:** Akron Cleveland Columbus Other: \_\_\_\_\_

**Circle all items that the camper now has or had in the past. Explain any circled items below or on a separate attached paper.**  
 Information may be shared with camp staff on a "need to know" basis.

Hospitalizations? Surgeries? Renal (kidney) disease? Recent infectious disease or recurring illness? Insomnia (difficulty sleeping)?  
 Mononucleosis (within 12 months)? Travelled outside the U.S.A. in the past 9 months? Chest pain or heart disease? Recent injuries?  
 Eating disorders? A significant life event in the past 12 months (family change, death of a loved one, survived a disaster, etc.)?  
 Bowel or bladder problems? Behavioral or emotional disorders? Menstrual difficulties (female)? Broken bones? Skin problems?

Swimming ability (check one)  Nonswimmer  Beginner (swims in waist high water)  Intermediate (swims in deep water)  
 Advanced (swims & dives with minimal supervision)

**Medication Information**

***All medications must be in their original containers and given to the nurse on arrival to camp.***

If your child has an Epi-pen, it **MUST** also be brought to camp and given to the nurse.

Will the camper bring any of the following to camp?

- |                       |                       |   |
|-----------------------|-----------------------|---|
| <u>YES</u>            | <u>NO</u>             |   |
| <input type="radio"/> | <input type="radio"/> | Will your child bring any medications to camp?                    |
| <input type="radio"/> | <input type="radio"/> | Does your child have an Epi-pen she/he will bring to camp?        |
| <input type="radio"/> | <input type="radio"/> | Prescription medications?   |
| <input type="radio"/> | <input type="radio"/> | Over-the-counter medications (include vitamins, sprays, topical)? |

Please complete the list for **all** medications - both prescription and over-the-counter - that your child takes. If more space is needed, please attach complete information about each medication on a separate paper.

**Specify dosages for ALL medications**, prescription and over-the-counter. Examples:

- ◆ Tylenol XS; NA; headaches/general pain; every 4 hours if needed; one 500 mg. oral caplet
- ◆ Robitussin; July 18; coughing; every 4 hours if needed; 1 Tbsp.; oral liquid
- ◆ Multivitamin; Aug 2011; good health; breakfast; 3 Gummy pieces; chew and swallow

Medication name	Date started	Reason taking it	Time medication is taken	Dose and quantity taken	How taken (capsule, liquid, shot, etc.)
			Breakfast Lunch Dinner Bedtime Other		
			Breakfast Lunch Dinner Bedtime Other		
			Breakfast Lunch Dinner Bedtime Other		

**Prescription medications** must be supplied from home in their original containers. **All medications** for the camper **must be in their original containers supplied from home** except the following over-the-counter medications, which *MAY* be available at the camp according to directions on the label for as-needed (NOT routine) situations. To be certain the camper gets regularly needed medications, supply them from home. Please cross out any that your child/the camper does NOT have your permission to be given.

Authorize administration of medications and any necessary treatment while at camp with your signature below.

- |                     |                           |                          |                         |
|---------------------|---------------------------|--------------------------|-------------------------|
| Adult Acetaminophen | Aloe                      | Children's Acetaminophen | Diphenhydramine         |
| Adult Aspirin       | Anti-itch lotion          | Children's Ibuprofen     | Guaifenesin cough syrup |
| Adult Ibuprofen     | Antibiotic ointment/cream | Cough drops              | Sore throat lozenges    |

Authorization for health care:

As parent or guardian of the above named camper, I give approval for my child to participate in camp activities and release all affiliated camp staff from liability for the camper's sickness, accidents or injuries during camp. I agree that this completed form is true and may be photocopied to ensure continued care of the camper, and information may be shared on an as-needed basis. In the event of an emergency, I consent to treatment deemed necessary by camp medical personnel or directors, and authorize medical help on site or at an appropriate medical facility.

Parent/Guardian printed legal name \_\_\_\_\_

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_