Summer Camp

Medical and Health History Form

(for campers/guests)

Contact Information

(to be completed, signed and dated by the Parent/Guardian)

Please mail this ENTIRE PACKET back to Monadnock Christian Ministries: *PO Box 70 Jaffrey, NH 03452

Name of Camper: _____

Dates Attending Camp: _____

Gender: Male_____ Female_____

Birth Date: _____/_____/_____ Age on Arrival at Camp: _____

Mailing Address1: _____

Street Address City/Town State/Province Zip Code

Mailing Address 2: _____

PO Box/Apt.# City/Town State/Province Zip Code

Parent/Guardian/Emergency Contact Information:

Provide more than one Emergency Contact, if desired

1. Name: _____ Relationship to Camper: _____

Preferred Phone Number: _____-_____-_____

Home Address: _____

Street Address City/Town State/Province Zip Code

2. Name: _____ Relationship to Camper: _____

Preferred Phone Number: _____-_____-_____

Home Address: _____

Street Address City/Town State/Province Zip Code

3. Name: _____ Relationship to Camper: _____

Preferred Phone Number: _____-_____-_____

Home Address: _____

Street Address City/Town State/Province Zip Code

Summer Camp
Medical and Health History Form
(for campers/guests)

General Health History

1. Restrictions (check one):

___ I have reviewed the camp and its activities and feel the camper can participate without restrictions.

___ I have reviewed the camp and its activities and feel the camper can participate with the following restrictions/adaptations:

Please Describe: _____

_____

_____

_____

2. Nutrition/Diet (check one): Please Contact the Food Service Director at least 14 days prior to your campers arrival at msnow@monadnockbible.org if the camper/guest has any food allergies and/or dietary restrictions.

___ This camper has no special diet and/or dietary restrictions

___ This camper does have a special diet and/or dietary restrictions

Please Describe: _____

_____

_____

3. Allergies (check all that apply):

___ No known allergies

___ Food

___ Medicine

___ Environment (insect stings, pollen, hay fever, etc…)

___ Other (list all)

Please Describe (include allergic reaction/s): _____

_____

_____

4. Medical Insurance Information (attach a copy of your insurance card; front and back):

This camper is covered by family medical/hospital insurance: YES ____ NO____

Insurance Company: _____ Policy Number: _____

Subscriber: _____ Insurance Co. Phone Number: _____

Summer Camp
Medical and Health History Form
(for campers/guests)

5. Other Medical Conditions: Circle "Yes" or "No" for each statement and describe "Yes" answers in the space provided. Attach an extra sheet of paper to this form if needed.

1. Ever been hospitalized: YES NO date(s): _____
2. Every had surgery: YES NO date(s): _____
3. Have recurrent/chronic illness: YES NO date(s) diagnosed: _____
4. Had a recent infectious disease: YES NO date(s): _____
5. Had a recent injury: YES NO date(s): _____
6. Had asthma/wheezing/short breath: YES NO date(s) diagnosed: _____
7. Have diabetes: YES NO date(s) diagnosed: _____
8. Had/has seizures: YES NO date(s) of last seizure: _____
9. Had/has chronic headaches: YES NO date(s) of last headache: _____
10. Wears glasses, contacts and/or protective eyewear: YES NO
11. Fainting or dizziness: YES NO date(s) of last incident: _____
12. Has/had chest pain during exercise: YES NO date(s) of last incident: _____
13. Had mononucleosis "mono" in the past 12 months: YES NO
14. If female, have problems with periods/menstruation: YES NO
15. Have problems falling asleep, staying asleep and/or sleep walking: YES NO
16. Back or joint problems: YES NO
17. Have a history of bedwetting: YES NO
18. Reoccurring diarrhea and/or constipation: YES NO date(s) of last incident: _____
19. Skin problems: YES NO
20. Traveled outside the country in the past 9 months: YES NO

Country: _____ Dates: _____

Country: _____ Dates: _____

Please describe any "YES" answers in the space below, noting the question(s) number(s):

Camper's Name: _____

6. Mental, Emotional and Social Health: Circle "Yes" or "No" for each statement and describe "Yes" answers in the space provided. Attach an extra sheet of paper to this form if needed.

1. Ever been treated for Attention Deficit Disorder (ADD) and/or Attention Deficit Hyperactive Disorder (ADHD): YES NO

2. Ever been treated for emotional and/or behavioral difficulties: YES NO

3. Ever been treated for an eating disorder: YES NO

4. Seen a professional in the past 12 months regarding mental/emotional/behavioral concerns: YES NO

5. Had a significant life event occur in the past 12 months that continues to affect the camper's life (i.e. death of a loved one, abuse, family change, adoption, foster care, survival of a disaster, etc) YES NO

Please describe any "YES" answers in the space below, noting the question(s) number(s):

Health Care Providers:

Name of camper's Primary Care Physician: _____ (Phone): _____

Name of camper's Dentist: _____ (Phone): _____

Name of camper's Orthodontist: _____ (Phone): _____

Please provide in the space below, any additional information regarding the camper's health that you believe may be important or that may affect the camper's ability to fully participate in the camp program. Attach additional information if needed.

Camper's Name: _____

Summer Camp
Medical and Health History Form
(for campers/guests)

6. Medication: This camper will **not** take daily medication(s) while at camp ____

This camper will take daily medication(s) while at camp ____

Medication is defined as any substance a person takes to maintain and/or improve their health. This includes vitamins, minerals and natural remedies. Monadnock Christian Ministries and New Hampshire State Law requires original pharmacy containers with labels that show the camper/guest's name and how much medication should be given. All medication is collected by the Camp Nurse during camper check-in and will be administered by the Camp Nurse daily per Monadnock Christian Ministries policy and New Hampshire State Law. **Parents/guardians should provide enough medication to last the camp session.** If you require more space to list all of the camper's medication(s), please use a separate sheet of paper and attach it to the Medical and Health History Form.

Name of Medication	Date Started	Reason for Taking It	When it is Given	Amount or Dose Given	How it is Given
			Breakfast Lunch Dinner Bedtime Other Time:		
			Breakfast Lunch Dinner Bedtime Other Time:		
			Breakfast Lunch Dinner Bedtime Other Time:		
			Breakfast Lunch Dinner Bedtime Other Time:		

The following non-prescriptive medications are stocked in our Camp Health Center and are used on an as needed basis by our medical professionals to manage illness and/or injury. Please cross out those medications the camper should not be given.

Acetaminophen (Tylenol)
Aloe
Topical Antibiotic Cream (bacitracin/triple antibiotic ointment)
Antifungal Spray/Powder
Calamine Lotion
Cough Syrup
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Electrolyte Drinks/Powders (Gatorade/Powerade)
Epinephrine (Epi-pen for severe allergic reactions)
Generic Cough Drops
Hydrocortisone Cream
Ibuprophen
Lice Shampoo or cream (Nix, Eliminate or mayonnaise)
Pseudoephedrine Decongestant (Sudafed)
Saline Eye Drops (Visine/Clear Eyes, etc...)
Sore Throat Gargle
Tums/Antacids

Camper's Name: _____

Summer Camp
Medical and Health History Form
(for campers/guests)

Authorization of Care: *"This health history and medical form is true, accurate and correctly reflects the physical, emotional and mental health status of the camper to whom it pertains. The camper has full permission to participate in all camp activities except as noted by me (the parent/guardian) and/or the examining physician. I give permission to physician(s), nurse(s) and/or medical professional(s) selected by camp leadership to order x-rays, routine tests and treatment related to the health of the camper for both routine health care and in emergency situations. If I cannot be reached in an emergency situation, I give permission to hospitalize and/or secure proper treatment for the camper. This treatment may include, but is not limited to: injection(s), anesthesia, surgery, immunization, lab work, radiological procedures, prescribing medication(s) and any other treatment(s)/procedure(s) necessary for medical care."*

Signature of Custodial Parent/Guardian: _____ Date: _____/_____/_____

Release of Liability: *"I understand and certify that my child's participation in Monadnock Christian Ministries's Ascend Summer Camps is completely voluntary, and I have familiarized myself with the program and activities my child will be participating in. I recognize certain hazards and dangers are inherent in Ascend Summer Camps and particularly, but not limited to: water tubing, wake boarding, water skiing, water sports/activities, tournaments, hatchet throwing, archery, riflery, pillow polo, gaga, volleyball, basketball, swimming, zip lining, low and high ropes course(s), wall climbing, group games, camp-wide mountain hikes and other activities. I acknowledge that although Monadnock Christian Ministries has taken safety measures to minimize risk, Monadnock Christian Ministries cannot guarantee the participants, equipment, facilities, premises, and/or activities will be free of hazards, accidents and/or injury. I further recognize and have instructed my child in the importance of knowing and abiding by all camp rules, policies and procedures for the safety of every guest, camper, and staff member. I sign this release of liability with full knowledge of the inherit risks of camp.*

Signature of Custodial Parent/Guardian: _____ Date: _____/_____/_____

Release of Medical Cost(s): *There may be times where a camper may not have health insurance. Whatever the reason, if the campers' parent/guardian cannot provide a copy of their health insurance card, front and back, it is the parent/guardian's responsibility to cover medical payment(s) incurred during a medical emergency. Monadnock Christian Ministries will not cover medical payment(s) due to a medical emergency. The parent/guardian will cover these costs.*

Signature of Custodial Parent/Guardian: _____ Date: _____/_____/_____

Immunization Agreement: *"I understand and accept the risks to my child not being fully immunized.* ***I understand a Tetanus Shot is a requirement of my child's attendance at camp and he/she may be denied registration if a Tetanus Immunization Record is not presented****. If my child is in a situation that requires a tetanus shot, and I cannot be reached by the camp, I give permission to camp leadership to send my child to a physician, hospital or clinic for a Tetanus Immunization."* ***If for religious or other reasons you wish to waive your child from presenting an immunization record, please contact Monadnock Christian Ministries at mbc@monadnockbible.org or by calling 603-532-8321.**

Signature of Custodial Parent/Guardian: _____ Date: _____/_____/_____

Camper's Name: _____

Summer Camp
Medical and Health History Form
(for campers/guests)

Physical Exam:

New Hampshire State Law requires a physician's report of physical examination for every camper and Guest. This physical exam MUST be performed any time in the 24 months preceding the camper's departure date. ***This physical examination must be performed by a licensed physician, physician's assistant or advanced licensed nurse practitioner; and they must complete and sign this form or equivalent form.***

Patient's Name: _____ Weight: _____ lbs Height: _____ ft _____ in

Blood Pressure: _____/_____ **Date of Patient's Physical Examination: _____**

Allergies: (list with reactions)

__ No known allergies

__ Food:

__ Medicine:

__ Environmental (insect stings, pollen, hay fever, etc…):

__ Other (list all):

Diet/Nutrition: No dietary restrictions_____ Has a medically prescribed diet, meal plan and/or restriction(s)_____

*Please Describe:

The camper is undergoing treatment at this time for the following conditions*:* NONE____

*Please Describe:

*Other Treatment(s)/Therapies to be continued at camp:

Do you believe this camper will require restrictions/limitations to activities while at camp? YES____ NO____

If "Yes", please describe:

"I have reviewed the Medical and Health History Form and discussed the camp program with the parents/guardians. It is my opinion the patient is physically and emotionally fit to participate in all camp activities (except as noted above)."

Name of Licensed Provider w/title (please print): _____

Signature: _____ Date: _____/_____/_____ Office Address: _____

Phone: _____

Summer Camp
Medical and Health History Form
(for campers/guests)

Immunization History

Provide the month and year for immunizations. Starred (*) immunizations must be current. Copies of immunization records from health-care providers, state or local governments are acceptable. Please attach to this Medical and Health History Form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose
Diphtheria, Tetanus, Pertussis* (DtaP or TdaP)						
Tetanus Booster* (dT or TdaP)						
Measles, Mumps and Rubella (MMR)*						
Polio* (IPV)						
Haemophilus influenza (HIB)						
Pnuemococcal (PCB)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) Had Chicken Pox__ Date(s):						
Meningcoccal Meningitis (MCV4)						

Tuberculosis (TB) Test	Date:	Negative____	Positive____

Patient's Name: _____