



BEAR CREEK CAMP

Explore, celebrate & grow in God's creation!

Youth Health Form

Session Name and Date _____

We encourage you to complete your health form online at bearcreekcamp.org/register if possible. If you are unable to, please complete this form and mail it to camp at least two weeks prior to your registered session. ALL Sections are REQUIRED. Information must be completed by the Parent/Guardian. Please provide complete information so that camp can be aware of your camper's needs and provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided and reviewed with camp health personnel upon participant's arrival at camp.

I. CAMPER & CONTACT INFORMATION

Camper Name _____ Birth Date _____ Gender _____ Age _____
Last First Middle

Home Address _____
Street & Number City State ZIP

First Parent/Guardian _____ Email _____
 Phone: Home (____) _____ Cell (____) _____ Work (____) _____

Second Parent/Guardian _____ Email _____
 Phone: Home (____) _____ Cell (____) _____ Work (____) _____

If not available in an emergency, notify:

Name _____ Phone (____) _____ Alternate Phone (____) _____ Relationship: _____
 Name _____ Phone (____) _____ Alternate Phone (____) _____ Relationship: _____

II. CARE PROVIDERS

Name of family physician _____ Phone (____) _____
 Name of dentist/orthodontist _____ Phone (____) _____
 Medical/hospital insurance carrier _____ I have no medical/hospital insurance ____

Please attach copy of insurance card (both sides).

III. MEDICAL CONSENT AGREEMENT

Participant's Name: _____

CERTIFICATION AND CONSENT TO AUTHORIZE MEDICAL CARE FOR MINOR.

By signing below I, the undersigned, am stating that I have legal custody of the Camper whose name is set forth above. I, the undersigned, hereby grant my authorization and consent to the Eastern Pennsylvania Lutheran Camping Corp dba Bear Creek Camp and their employees, clinicians, trainers, nurses, or agents to administer first aid treatment for any minor injuries or illnesses and, if the injury is life threatening or in need of emergency treatment, to seek, approve, and obtain any medical, dental or surgical diagnosis, treatment or care for the Camper including, but not limited to, x-ray, anesthetic, injections, medications, blood transfusions, and hospitalization, which is deemed advisable by, and is to be rendered under the general supervision of a physician, surgeon, dentist, hospital or other medical professional or institution. I authorize the release of any and all medical records concerning the Camper to any health care provider authorized to provide care or treatment pursuant to this Medical Consent Agreement. I, the undersigned, agree to assume financial responsibility for all expense of such care. I, the undersigned, have read, and I understand, all of the provisions of this Agreement.

Parent or Guardian's Signature _____ Date _____ Participant's Signature _____ Date _____
 Parent or Guardian's Name (Printed) _____ Participant's Date of Birth _____

IV. HEALTH HISTORY:

Height: _____ Weight: _____ Date of Last Medical Exam: _____

Has your child experienced, or is currently experiencing, any of the following conditions?

- | | Yes/No | | Yes/No |
|--|---|--|---|
| 1. Recent injury, illness or infectious disease?..... | <input type="checkbox"/> <input type="checkbox"/> | 19. Joint problems?..... | <input type="checkbox"/> <input type="checkbox"/> |
| 2. Chronic or recurring illness/condition?..... | <input type="checkbox"/> <input type="checkbox"/> | 20. Wears a removable orthodontic appliance? | <input type="checkbox"/> <input type="checkbox"/> |
| 3. Ever been hospitalized?..... | <input type="checkbox"/> <input type="checkbox"/> | 21. Skin problems?..... | <input type="checkbox"/> <input type="checkbox"/> |
| 4. Ever had any operations?..... | <input type="checkbox"/> <input type="checkbox"/> | 22. Diabetes? | <input type="checkbox"/> <input type="checkbox"/> |
| 5. Frequent headaches?..... | <input type="checkbox"/> <input type="checkbox"/> | 23. Asthma/Inhaler? | <input type="checkbox"/> <input type="checkbox"/> |
| 6. A head injury?..... | <input type="checkbox"/> <input type="checkbox"/> | 24. Mononucleosis in the past 12 months? | <input type="checkbox"/> <input type="checkbox"/> |
| 7. Knocked unconscious?..... | <input type="checkbox"/> <input type="checkbox"/> | 25. Problems with diarrhea/constipation?..... | <input type="checkbox"/> <input type="checkbox"/> |
| 8. Wears glasses, contacts, or protective eye wear?..... | <input type="checkbox"/> <input type="checkbox"/> | 26. Irritable Bowel Syndrome ? | <input type="checkbox"/> <input type="checkbox"/> |
| 9. Frequent ear infections?..... | <input type="checkbox"/> <input type="checkbox"/> | 27. Crohn's? | <input type="checkbox"/> <input type="checkbox"/> |
| 10. Passed out during or after exercise? | <input type="checkbox"/> <input type="checkbox"/> | 28. Colitis? | <input type="checkbox"/> <input type="checkbox"/> |
| 11. Been dizzy during or after exercise? | <input type="checkbox"/> <input type="checkbox"/> | 29. Sleepwalking?..... | <input type="checkbox"/> <input type="checkbox"/> |
| 12. Had seizures?..... | <input type="checkbox"/> <input type="checkbox"/> | 30. If female, abnormal menstrual history?..... | <input type="checkbox"/> <input type="checkbox"/> |
| 13. Had chest pain during or after exercise?..... | <input type="checkbox"/> <input type="checkbox"/> | 31. History of bed-wetting?..... | <input type="checkbox"/> <input type="checkbox"/> |
| 14. Had high blood pressure?..... | <input type="checkbox"/> <input type="checkbox"/> | 32. Ever had an eating disorder?..... | <input type="checkbox"/> <input type="checkbox"/> |
| 15. Bleeding/clotting disorder?..... | <input type="checkbox"/> <input type="checkbox"/> | 33. ADD/ADHD? | <input type="checkbox"/> <input type="checkbox"/> |
| 16. AIDS/ARC? | <input type="checkbox"/> <input type="checkbox"/> | 34. Speech challenges? | <input type="checkbox"/> <input type="checkbox"/> |
| 17. Diagnosed with a heart murmur? | <input type="checkbox"/> <input type="checkbox"/> | 35. Ever had emotional difficulties for which
professional help was sought? | <input type="checkbox"/> <input type="checkbox"/> |
| 18. Back problems?..... | <input type="checkbox"/> <input type="checkbox"/> | | |

Please explain "yes" answer(s) from above, noting the number of the question(s).

Please share any other information about the participant's behavior and physical, emotional, or mental health that may be helpful to our staff in meeting the needs of your youth.

V. RESTRICTIONS

The following dietary restrictions apply to this individual:

Explain any activity restrictions (e.g., what cannot be done, what adaptations or limitations are necessary).

VI. IMMUNIZATION HISTORY

* To protect the health of those who are medically unable to receive immunizations, we encourage campers to be vaccinated prior to the start of camp.

Please give all dates of immunizations: you may attach a record from your doctor or the state health department.

	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
Tetanus	_____	_____	_____	_____	_____	_____
DTP	_____	_____	_____	_____	_____	_____
TD (Tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____	_____
or Measles	_____	_____	_____	_____	_____	_____
or Mumps	_____	_____	_____	_____	_____	_____
or Rubella	_____	_____	_____	_____	_____	_____
Haemophilus InfLuenza B (<i>Hib B</i>)	_____	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	_____	_____
Varicella (Chicken pox)	_____	_____	_____	_____	_____	_____

If your child has not been fully immunized, please explain: _____

Which of the following diseases has the participant had?

- | | | | |
|--------------------------------------|---|--------------------------------------|---|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> German Measles |

COVID- 19- Please list the month/date of vaccinations and boosters _____

VII. ALLERGIES

Please list all known Allergies. Describe reaction and management of the reaction.

Medication:

_____	_____
_____	_____
_____	_____

Food:

_____	_____
_____	_____
_____	_____

Insect stings/Bees:

_____	_____
_____	_____
_____	_____

Other:

_____	_____
_____	_____
_____	_____
_____	_____

VIII. MEDICATION AUTHORIZATION

Camper Name: _____ Birth Date: _____ Camp name _____

I approve the administration of the following over-the-counter medications by the camp health staff as needed:

- Ibuprofen and/or Acetaminophen (Tylenol) for headache, minor discomfort or fever
- Hydrocortisone cream and/or Benadryl for itching/discomfort caused by irritants and/or allergies.
- Insect Repellent
- Sunscreen
- Antacid Sting Swabs Antibiotic Cream (TAO, Neosporin)

I am sending the following Prescription and/or over-the-counter Medications with my child:

Please keep all medications (prescription or over-the-counter) in original containers. Blister packs welcome.

ALL medications should be listed on this form and clearly labeled with:

- 1) Camper name; 2) Name of medication; 3) Dosage; 4) Frequency of administration; 5) Method of administration;

and

If the medication has been prescribed by a physician, the label *must* also include:

- 6) Name of prescribing physician; 7) Prescription number; 8) Date prescribed; 9) Possible adverse reactions;
- 10) Specific conditions when contact should be made with physician; 11) Other special instructions:

Name of Medication _____ Date Prescribed: _____
Dosage: _____ Frequency: _____ Method of Administration: _____
Possible Side Effects: _____
Special Instructions: _____
Why has this medication been prescribed? _____
Contact the Physician When: _____

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Dosage: _____ Frequency: _____ Method of Administration: _____
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Dosage: _____ Frequency: _____ Method of Administration: _____
Possible Side Effects: _____
Special Instructions: _____
Why has this medication been prescribed? _____
Contact the Physician When: _____

*** Please add additional pages as needed.

IX. PICK-UP AUTHORIZATION

_____ is authorized to pick up _____ at the conclusion of camp.
(Name of person authorized to pick up camper) (Camper Name)

(Signature of Parent/Guardian)

(Date)