

Camper Health Form

Missouri United Methodist
 Camping and Retreat Ministries
 3601 Amron Ct., Columbia, MO 65202
 Phone: 573.442.7909

Name <i>(Last, First, M.I.):</i>		DOB:	
Health Insurance/Medicaid Policy# (Required)		Camp Event Code:	
Group #	Policy Holder's Name:	Medical ID#	
Primary Physician's Name:		Physician's Phone:	
Childhood illness <small>(please check if camper has had any of the following):</small> <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio <input type="checkbox"/> Hep A, B, and/or C			
Immunizations and dates REQUIRED: Please list the date of most recent shot OR attach copy of Immunization Record. A child is exempt from submitting records if a parent objects in writing on a Department of Health and Senior Services Form Imm.P.11A. A copy of this form is required for exemption.	<input type="checkbox"/> Tetanus <small>(date of last shot)</small>	<input type="checkbox"/> PCV <small>Pneumococcal (3 doses)</small>	<input type="checkbox"/> Hepatitis A <small>Optional (2 doses)</small>
	<input type="checkbox"/> Hep B <small>Hepatitis B 3 doses</small>	<input type="checkbox"/> IPV-polio <small>(4 doses)</small>	<input type="checkbox"/> MCV4 <small>Meningococcal (Ages 11-12)</small>
	<input type="checkbox"/> RV <small>Rotavirus 3 doses</small>	<input type="checkbox"/> Influenza <small>(Optional/Yearly)</small>	<input type="checkbox"/> HPV <small>Age 11 (3 doses, female)</small>
	<input type="checkbox"/> DTaP <small>Diphtheria, Tetanus, Pertussis (ages up to 6, 4-5 doses)</small>	<input type="checkbox"/> MMR <small>Measles, Mumps, Rubella 2 doses</small>	<input type="checkbox"/> TdaP <small>(ages 11-12) Tetanus, Diphtheria, Pertussis</small>
	<input type="checkbox"/> Hib <small>Haemophilus influenza type b(3-4 doses)</small>	<input type="checkbox"/> Varicella/Chicken POX <small>(Chicken Pox 2 doses)</small>	
Camper lives with: <input type="checkbox"/> Both parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Self (18 or older) <input type="checkbox"/> Other (please specify) _____			
Known Allergies (Food, Drugs, Plants, Animals, Insects and/or Others):			
Any operations, serious injuries or chronic illness:			
Medications: List all medications, prescription and non-prescription, dosage and frequency. All medications brought to camp must be in the original containers, clearly labeled with camper's name and dosage instructions and placed in a Ziploc bag.			
The Camp Health Supervisor is authorized to give my camper, as needed (yes or no):			
Ear drops for swimmer's ear	Antacids for upset stomach	Throat lozenges for soreness	Sudafed/pseudoephedrine
Calamine Lotion	Benadryl/Diphenhydramine	Cough Medicine/Cough Drops	
Tylenol/Acetaminophen	Motrin/Ibuprofen	Medication for diarrhea	
Check all that apply:			
<input type="checkbox"/> Fainting <input type="checkbox"/> Bedwetting <input type="checkbox"/> Bleeding/Clotting <input type="checkbox"/> Nightmares/Night Terrors <input type="checkbox"/> Frequent Ear Infections <input type="checkbox"/> Stomach Upsets <input type="checkbox"/> Seizures			
<input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Problems <input type="checkbox"/> Autism/Azberger's <input type="checkbox"/> Musculoskeletal disorders <input type="checkbox"/> Asthma/Respiratory Problems <input type="checkbox"/> Eating Disorder <input type="checkbox"/> ADD/ADHD			
<input type="checkbox"/> Motion sickness/Dizziness <input type="checkbox"/> Emotional Difficulties <input type="checkbox"/> Wears contacts, glasses or protective eyewear <input type="checkbox"/> Mononucleosis in last 12 months			
<input type="checkbox"/> Wears a Medic Alert ID <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Sleepwalking <input type="checkbox"/> Frequent Headaches <input type="checkbox"/> Homesickness <input type="checkbox"/> Chest Pain <input type="checkbox"/> Joint problems			
Any known physical, mental or social difficulties which may affect participation and/or which special considerations should be given?			
For females (minors), has she menstruated? <input type="checkbox"/> YES <input type="checkbox"/> NO If not, has she been told about it? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Special Diet needs or requests (i.e. lactose intolerant, no milk products):			
Any activity restriction desired by participant, his or her guardian or physician? Explain.			

Release and Consent for Medical Treatment and Medications

I, the undersigned, hereby give my consent for my child to participate in the United Methodist enterprise for which he/she is enrolled, and in consideration for allowing my child to participate, I release any and all rights or claims for damages against the Missouri Conference Camping and Retreat Ministries, Missouri Camp, Inc., and/or the Missouri Annual Conference of The United Methodist Church, and all individuals assisting or instructions and conducting these activities, for any and all injuries, loss, or damage suffered by my child while attending said enterprise.

I give my consent to the camp health supervisor to administer medications that I provide for my child, following my directions or the directions of the prescribing physician. The camp health supervisor may also administer over-the-counter medication as needed for the well-being of my child; unless I otherwise restrict its use. In the event that my child is injured or becomes ill while participating in an activity related to the enterprise for which he/she is enrolled, I hereby give permission for reasonable medical care and treatment to be administered to my child by the camp health supervisor and/or physician selected by the camp director/health supervisor.

Signed by Camper or Parent/Legal Guardian if under 18: _____ Date: _____
 If Parent/Legal Guardian list name and relation to camper _____