

For camp office use only:

Camp session/year \_\_\_\_\_ Counselor \_\_\_\_\_ Cabin \_\_\_\_\_



# HEALTH HISTORY and MEDICAL INFORMATION

(To be completed and signed by parental guardian; please print legibly in ink.)



## GENERAL INFORMATION

Camper's first & last names \_\_\_\_\_ Gender \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Parent(s)/guardian(s) \_\_\_\_\_ Home phone \_\_\_\_\_ Cell \_\_\_\_\_

Mailing address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code+4 \_\_\_\_\_

Work telephone numbers (if applicable) of Mother \_\_\_\_\_ Father \_\_\_\_\_

Family physician's name \_\_\_\_\_

*If applicable:* Affiliated clinic/town of family physician \_\_\_\_\_ Telephone \_\_\_\_\_

If a parental guardian is not available in case of emergency, notify:

Name(s) \_\_\_\_\_ Telephone(s) \_\_\_\_\_

## HEALTH HISTORY and MEDICAL INFORMATION (CHECK ALL THAT ARE PERSISTENT HEALTH PROBLEMS.)

ADD/ADHD  Anorexia/Bulimia  Appendicitis  Arthritis  Asthma  Bedwetting  Behavior challenges

Bladder/Kidney problems  Constipation  Convulsions/seizures  (*If applicable, type*) \_\_\_\_\_ Depression

Diabetes  Diarrhea  Ear infections  Eczema  Epilepsy  Fainting spells  Hay fever  Headaches

Heart trouble  Hepatitis and/or known carrier  Homesickness  Hypertension  Measles  Menstrual cramps

Mumps  Nervousness  Nosebleeds  Rheumatic Fever  Sinus trouble  Sleep Walking  Ulcers

Other chronic or recurring illnesses \_\_\_\_\_

(Please include any necessary information regarding treatment or management.)

Please contact program director Melissa Reinhart (701-263-4788) at least one week prior to your child's arrival at camp if there are any special challenges or considerations (e.g., diabetes; severe asthma; emotional, behavioral, or social disorder) for which our staff should prepare that will impact your child's camp experience. We want to meet your child's needs as best we can.

Surgeries or serious injuries and dates \_\_\_\_\_

ALLERGIES: foods/medications/insects, etc. \_\_\_\_\_

Dietary concerns/restrictions \_\_\_\_\_

MEDICATIONS - All medications will be administered by camp staff except inhalers which will be self-administered by camper. All prescription medication must be appropriately labeled. Please list any routine daily medications including dosage and directions.

The camp has a supply of Tylenol, cough medicine, decongestants, antacids, and first-aid ointments which will be used as indicated following label instructions, so campers do not need to bring their own. Please state any concerns or give instructions regarding use of over-the-counter medications.

Physical activities to be encouraged or restricted \_\_\_\_\_

**IMMUNIZATIONS** (Month/Year) COMPLETION IS MANDATORY! **DO NOT** use “current” or “up-to-date.”

DPT/DTaP/DT/Td	1	2	3	4	5	6
OPV/IPV	1	2	3	4		
MMR	1	2				
Varicella (chicken pox)	1	2	Date of disease:			
Hepatitis B (HBV)	1	2	3			
Hib	1	2	3	4		
Other:						

**DPT/DTaP/DT/Td** (Diphtheria, Tetanus, Pertussis) - due at 2 months, 4 months, 6 months, 12-15 months, and 4-6 years old; Pertussis portion of vaccine not given to older children; after last DTaP/DT shot, **BOOSTER IS NEEDED EVERY 7-10 YEARS**

**OPV/IPV** (Polio) - due at 2 months, 4 months, 12-15 months, and 4-6 years old

**MMR** - due at 12-15 months and 4-6 years old. Some older campers will not have 2nd dose (needed before college if not 2 doses).

**Varicella** - optional vaccine for children without history of chicken pox; one or two doses

**Hepatitis B** - not required, but strongly recommended for children born after 10/1/92

**Hib** - vaccine not given to children above age 5 (vaccine for Haemophilus b causes meningitis in children)

**FAMILY MEDICAL/HOSPITAL INSURANCE INFORMATION**

Insurance Carrier \_\_\_\_\_ Name of Insured \_\_\_\_\_

Group Policy Number \_\_\_\_\_ Insured’s Policy Number \_\_\_\_\_

**PARENTAL GUARDIAN’S SIGNATURE TO THE FOLLOWING IS REQUIRED.**

I attest that the health history and medical information are correct to the best of my knowledge. The person herein described has permission to engage in all prescribed camp activities, except as noted by me. I agree that Metigoshe Ministries and/or its personnel will not be held responsible for accidents or personal injury arising therefrom.

EMERGENCY AUTHORIZATION: I hereby give permission to the medical personnel selected by the camp director to order X-rays, perform routine tests, and treat my child; and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment, and order injection and/or anesthesia and/or surgery for my child named herein. I give my approval to photocopy this form for use out of camp.

PARENTAL GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**PLEASE DO NOT MAIL OR BRING TO CAMP EARLY, PRESENT AT TIME OF FINAL REGISTRATION.**

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**PARENT’S PERMISSION TO RELEASE**

(if applicable)

It is the policy of Metigoshe Ministries to not release any minor camper into the custody of anyone other than the camper’s legal parent(s) or guardian(s) unless written consent is given by such parent or guardian.

Therefore, **IF** your child is to be released to a person(s) who is **NOT** his/her legal guardian, please complete the following.

Please release my child \_\_\_\_\_  
(print Camper’s Name)

into the custody of \_\_\_\_\_  
(print Name of Person who is **not** the legal parent or guardian)

SIGNATURE OF LEGAL GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_