Medical Information Form
Dakotas-Minnesota Area
United Methodist Camp & Retreat Ministries

Please bring this completed form to camper check-in, or complete the form in your online account at least 10 days prior to camp.

This form is **MANDATORY** and must be completed by the parent or legal guardian of any participant under age 18 attending camping events. This form is **REQUIRED** at the time of camper check-in and the *Authorization Information* section (back page) **MUST** be signed.

Camp or Event: _____ **Camp Number:** _____

	Camper Information	Name:	Preferred Name:
		Address, City, State, Zip:	
		Birthdate:	Grade Completed:
		Gender:	Preferred Pronouns:
	Parent/Guardian #1 with legal custody to be contacted in case of illness or injury:	Name:	Relationship to camper:
		Home Address (if different from above):	
		City, State, Zip:	
		Cell Phone: ( )	Work Phone: ( )
		Email address:	
	Parent/Guardian #2 or another emergency contact: (not required)	Name:	Relationship to camper:
		Home Address (if different from above):	
		City, State, Zip:	
		Cell Phone: ( )	Work Phone: ( )
		Email address:	
	Emergency Contact in case parent(s) or guardian(s) cannot be reached: **REQUIRED**	Name:	Relationship to camper:
		Cell Phone: ( )	Alternate Phone: ( )
		Email address:	

Insurance Informatio	**Please attach a copy of the front and back of health insurance card.**
	Is the camper covered by **family medical/hospital insurance**? ☐ Yes ☐ No
	If so, indicate insurance company or plan name:
	Policy or Group #:
	Insurance company phone number:
	Policy holder name:

Healthcare Providers	**Name of Camper's Healthcare Providers**	**Phone:**
	Primary doctor(s):	( )
	Dentist:	( )
	Orthodontist:	( )

Allergy Information	☐ **This camper has NO known allergies**	
	The camper is allergic to:	Please describe **what the camper is allergic to, the reaction seen, and how it is treated**. Make sure to note if any of these allergies **cause anaphylaxis**.
	☐ **Food(s)**	☐ **Causes Anaphylaxis**
	☐ **Medicine(s)**	☐ **Causes Anaphylaxis**
	☐ **The environment (insects, hay fever, etc.)**	☐ **Causes Anaphylaxis**
	☐ **Other**	☐ **Causes Anaphylaxis**

Diet/ Nutrition Information	
	☐ This camper eats a **Regular Diet with *no restrictions***
	☐ This camper eats a **Vegetarian Diet**
	☐ This camper eats a **Vegan Diet**
	☐ This camper has the following **special dietary *restrictions* or *modifications***:

Medication Information (Use additional pages as necessary)

Medication is any substance a person takes to maintain and/or improve their health. This includes vitamins and natural remedies. All medications are collected, stored, and distributed by camp health care personnel. **Please list ALL medications this camper will be taking while at camp**, including over-the-counter medications or non-prescription drugs taken routinely. **Provide enough of each medication to last the entire time the camper will be at camp.** *Keep medications in the **original packaging/pharmacy container with labels** that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.*

☐ **This camper will not take any daily medications while attending camp**

☐ This camper will take the following *daily medication(s) while at camp:

Name of Medication:	Reason for taking:	Times Given:	Amount/Dose Given:	How dose is given:	Pill Count:		Initials: *(guardian and staff)*
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other:			In:		
					Out:		
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other:			In:		
					Out:		
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other:			In:		
					Out:		
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other:			In:		
					Out:		
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other:			In:		
					Out:		

*Please **circle** any medication listed above that has been **newly prescribed (within the past 3 months) or if the dose has been recently changed**.

Staff ONLY – Do you require any medication that might impair your ability to perform the essential functions of your position? ☐ **No** ☐ **Yes - If yes, staff member must discuss details with the camp healthcare provider.**

Over-the-counter Medications

Many commonly used non-prescription medications are stocked in the camp Health Center and are used on an <u>as-needed basis</u> to manage illness and injury. **DO NOT SEND OVER THE COUNTER MEDICATIONS WITH YOUR CAMPER unless they are taken routinely.**

☐ Camp staff **<u>has permission</u>** to administer **over-the-counter** medications, as necessary.

☐ Camp staff has permission to administer **over-the-counter** medications as necessary, **<u>except the following</u>**:

☐ This camper **<u>should not be given</u>** any **over-the-counter** medications.

Immunization, Disease, and Exam History

	YES	NO
Are the camper's immunizations/vaccinations up to date according to state school standards? If no, please explain:		
Has the camper been exposed to any **communicable diseases** recently? If yes, please explain:		
Has the camper ever had a positive **TB Mantoux test**? If yes, date of positive test: _____		
Date of last **Tetanus vaccine**:		
Date of last **Health Exam**:		

General Questions

Has/Does this camper:	YES	NO	Has/Does this camper:	YES	NO
1. Ever been hospitalized?			11. Had fainting or dizziness?		
2. Ever had surgery?			12. Passed out or had chest pain during exercise?		
3. Have recurrent or chronic illnesses?			13. Had mononucleosis (mono) during the past 12 months?		
4. Had a recent infectious disease (e.g., flu)?			14. If female, have problems with periods/menstruation?		
5. Had a recent injury?			15. Have problems with falling asleep, sleepwalking or nightmares?		
6. Had asthma, wheezing or shortness of breath?			16. Ever had back or joint problems?		
7. Have diabetes?			17. Have a history of bedwetting?		
8. Had seizures or other neurological issues?			18. Problems with diarrhea or constipation?		
9. Have recurring headaches or migraines?			19. Have any skin problems?		
10. Wear glasses, contacts, or protective eyewear?			20. Traveled outside the country in the past 9 months?		

Please explain YES answers in the space below, noting the number of the question. For travel outside the country, please name countries visited and dates of travel:

Mental, Emotional and Social Health

Has this camper:	YES	NO
Ever been **diagnosed with and treated for** attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD)?		
Ever been **diagnosed with and treated for** emotional or behavioral difficulties, or an eating disorder?		
Seen a professional to address mental/emotional health concerns **during the last 12 months**?		
Had a **significant life event** that continues to affect the camper's life? *(e.g., divorce, history of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, other)*		

Please explain YES answers in the space below, attaching a separate sheet if more space is needed:

Restriction Information	
	☐ I have reviewed the program and activities of the camp and feel that this **camper can participate without restrictions.**
	☐ I have reviewed the program and activities of the camp and feel this **camper can participate with the following restrictions or adaptations**. Please describe below. (*To be discussed with health care staff at camp check in.)*

Additional Information		YES	NO
	Would you like **gender identity accommodations**? If yes, please list request below:		
	YOU WILL BE CONTACTED IF: • Your camper is exposed to a communicable disease. • Outside medical attention is necessary (i.e., if we transport your camper to a hospital or doctor's office.) • Your camper is having discipline problems that jeopardize the safety of others		
	WHAT HAVE WE FORGOTTEN TO ASK? *In the space below, **please provide any additional information** about the camper's health that you think important for us to know or that may affect the camper's ability to fully participate in the camp program. Attach additional information if needed.*		

Authorization Information		
	AUTHORIZATION FOR CAMPER HEALTH CARE This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of this camper for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this camper. I understand the information on this form will be shared on a "need-to-know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of the camper's health record from providers who treat the camper, and these providers may talk with the program's staff about this camper's health status. I understand that camp insurance is a supplemental policy only. It will pay whatever my own insurance does not cover (deductible or over) up to the limit of the policy. If medical (sickness, injury) care is needed, billings will be sent to the parent/guardian who will be responsible for direct payments to physician, hospital, clinic, etc.	
	Signature of Custodial Parent/Guardian:	**Date:**
	Relationship to camper:	

Camper Ride Home	**My camper will be riding home with:**	**Contact information**
	Name:	Cell Phone: ( )
	Relationship to camper:	Alternate Phone: ( )

Staff Use Only		Yes	No		Yes	No
	Recent exposure to communicable disease, illness, injury?			Any allergies?		
	Authorization section signed?			Meds checked-in? Pill counts documented?		
	Anything that requires follow-up?			All info current and complete?		
	Staff Initials:			Date:		