**Adult Health Form**

Michigan Area United Methodist

Camping

P.O. Box 134

St Johns, Mi 48879

989-534-6587

 Campers over 18 and camp staff must submit a completed form for themselves



For Office Use:

Date completed

Name-Last First Nickname

Street Address City State Zip

date of birth mm/dd/yyyy Phone Number

Camp session if applicable

Emergency Contact Name/Relationship Emergency Contact Number (cell preferred)

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**AUTHORIZATION** Please read and sign, indicating your authorization:

Routine Care: I grant permission for the Health Officer to give me first aid and treat illnesses in accordance with the camp’s Standard Care Procedures approved yearly by a physician.

Emergency Care: I grant permission to the camp Health Officer to secure emergency medical/surgical treatment, if necessary, for the person named on this form while at camp. I give permission to be transported for treatment, if the Health Officer deems it safe, in a private camp vehicle, or by ambulance if indicated for my safety. Costs associated with illness/injury-the camp will not be responsible for any costs incurred as a result of treatment or transportation due to illness or injury.

Assumption of Risks: Having read the camp description, I understand there are risks inherent to camping activities (outdoor activities, sports, aquatics, etc.).

**Signature: Date**

**INSURANCE:** Is the camper covered by medical/hospital insurance? 🞏 yes 🞏 no

Please bring a front-and-back photocopy of your insurance card to check-in at camp, OR complete the fields below

Name of primary insurance provider Name of Health Insurance Company

Contact Number: Plan Code: Group Number:

Primary Physician Phone number

**Allergies**  🞏 I have no known allergies

**Food allergies.** Describe food, reaction and management

**Environmental allergies** Describe reaction and management

**Medication allergies**. Describe reaction and management

**NUTRITION:** The camp kitchen can work to accommodate food allergies and most medically prescribed diets, but can not cater to individual food preferences Describe any dietary needs or restrictions. (Vegan, Vegetarian, Gluten, lactose intolerant) Contact the

camp 2 weeks prior to camp to make arrangements.

**Medications Medications must be given to the camp Health Officer at check-in for dispensing at the designated times. All medications (over the counter and prescription) by law must be locked securely in the Camp Health Center if you are in a living situation with campers. Talk with the Health Officer for exceptions (inhalers, epi pens) ALL MEDICATIONS MUST BE SENT IN THEIR ORIGINAL CONTAINERS, LABELED FOR YOU WITH MEDICATION NAME, DOSAGE/FREQUENCY TO BE GIVEN AND THE NAME OF THE PRESCRIBING PHYSICIAN ON THE LABEL** Medications are dispensed at meals and bedtime unless it is critical, they be given at a different time (anti-seizure, psych meds)

Please list medications to be given at camp, both prescription and non-prescription. State the drug name, dosage, frequency, time of day to be given

Medication #1:

Medication #2:

Medication #3:

Medication #4:

Medication #5:

Medication #6

Inhalers used as needed 🞏 Kept (report to the health officer when used) 🞏 Given to Health Officer

Are you taking any medications that might affect your ability to preform the functions of your job description? (Discuss with the camp director if yes)

**The camp stocks the following medication. Please do not send additional amounts unless given routinely.**

Acetaminophen (Tylenol) Ibuprofen (Motrin) Diphenhydramine (Benadryl) Decongestant, Allergy medicine-loratadine (Claritin), Antacid, Cepecol throat lozenges, Calamine lotion, Cough drops, Cough suppressant, Imodium (Anti-diarrhea) Hydrocortisone Cream

**Please Check one** 🞏 It is ok to give me these if indicated per camp Standard Orders

 🞏 It is ok to use these meds except \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH CONDITIONS**:

Please check all that are applicable. 🞏 Have had a recent injury, illness, surgery

 🞏 Have a chronic illness/condition (ear aches, sore throats) 🞏 Have had or have a back pain/injury

 🞏 Have had a seizure 🞏 Have a heart defect/heart disease

 🞏 Have asthma, wheezing, hay fever 🞏 Have hypertension

 🞏 Have diabetes 🞏 Allergic to bee stings

 🞏 Have Arthritis 🞏 Smoke

 🞏 Have an irregular heart beat 🞏 Have had Flu, COVID immunizations

 🞏 Have had a concussion **Date of last tetanus shot**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 🞏 Have a diagnosis of depression, Panic/anxiety disorder or other psychiatric diagnosis

Describe any activity restrictions and/or other past, or ongoing medical care or conditions not listed

Tuberculin (TB) test (if required) Date Type Results

Chest X-Ray if skin test is positive Date Results

**E-signature**

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_