Camp and Retreat Ministries
4784 N. Lombard St. Ste B.
PMB #203 Portland, OR 97203

Phone: 503-802-9214

Health History - Adult

For:

Please complete this form to the best of your ability. We request this information so that we are prepared should a medical emergency arise.

Please list any dietary needs and food allergies. Please include any allergic reaction details:

Do you require an Epi Pen?

○ Yes ○ No

Are you current on your vaccinations?

○ Yes ○ No

If you are not current on vaccinations, please explain why:

What is the date (month/year) of your most recent tetanus immunization?

Please mark any of the following conditions you are currently experiencing. Please include any additional information below:

- ☐ ADD/ADHD
- ☐ Behavioral Issues
- ☐ Chest pain
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Neck Pain or Injury
- ☐ Sleepwalking
- ☐ Asthma/Inhaler
- ☐ Bleeding disorder
- ☐ Concussion (current-past 2 years)
- ☐ Epilepsy
- ☐ Kidney Disease
- ☐ Respiratory Ailments
- ☐ Back Pain or Injury
- ☐ Cancer (undergoing treatment?)
- ☐ Depression
- ☐ Heart Disease
- ☐ Mental Health Issues
- ☐ Seizures

Please include any additional information regarding the condition(s).

Have you had any operations, hospitalizations or serious injuries in the last 3 years that will affect your time at camp? If so, please explain.

Do you have any restrictions on activity? If yes, please explain what activities must be restricted and list any special accommodations that should be made.

Will you require any special assistance while at camp? If yes, please explain what assistance will be required.

For:

Please list any health information regarding current or on-going physical, mental, emotional, social health, developmental, or psychological conditions the camp should know.

Is there anything you would like to discuss with the camp medical staff?

Family Doctor and Phone:

Insurance information. Please provide:
Full Name of Policy Holder, Insurance Company/Plan Name, Health Insurance Policy Number, Insurance Group Name or Number, (Enter N/A if you don't have insurance)

PERMISSION TO TREAT: I hereby certify that this information is correct. In case of medical emergency, I understand that every effort will be made to contact the emergency contact I have provided. In the event they cannot be reached, I hereby give permission to the medical personnel selected by the camp to secure and administer treatment, including hospitalization, and to provide or arrange necessary related transportation for me.

Medical providers are authorized to disclose protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health-care provider involved in providing medical care.

I agree to the release of any records necessary for insurance purposes. A printed version of this completed health form may be photocopied for trips out of camp.

Typing your name below confirms that you have read the medical waiver, that you understand it, and that you agree to be bound by it. If you do not agree to this waiver, you will not be able to attend camp.

I hereby certify that this information is correct and complete to the best of my knowledge.

Signature _____ Date _____