Health History Form for Adults Attending Camps or Retreats

Camp & Retreat Ministries
Oregon-Idaho Conference

Dates of Camp Attendance _____
Name of Camp or Event _____
Site: Latgawa Magruder Suttle Lake Sawtooth Wallowa Lake

This form should be sent in to the camp at least 10 days prior to your arrival so that the camp staff can be aware of your needs. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp.

Mail this form to the **camp** at least 10 days before the first day of camp.

PERSONAL INFORMATION:

Name _____ (Last / First / Middle Init.)
Home address _____ Gender: (circle one) **Male** **Female**
City _____ State _____ Zip _____ Birthdate _____
Home Phone ( ) _____
Daytime Phone (if different) ( ) _____ Email Address: _____

EMERGENCY CONTACT:

Whom should we notify in case of a medical emergency?
Name _____ Relationship _____
Address _____ Phone ( ) _____
City _____ State _____ Zip _____ Work/Other phone _____

HEALTH CONDITIONS:

Any known allergies? _____ Yes _____ No
Allergies to medications: _____
Food allergies: _____
Other Allergies: _____

List any **dietary restrictions**: _____

Date of Last Tetanus Shot _____ Blood Type _____ *(if known)*
Do you have a health condition (e.g. allergies, chronic conditions) or special circumstances that may affect program participation, special housing need, or anything we ought to know prior to emergency treatment? **Yes** **No**
If yes, please explain: _____

MEDICATIONS BEING TAKEN:

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

Med#1 _____ Dosage _____ Schedule _____
Med#2 _____ Dosage _____ Schedule _____
Med#3 _____ Dosage _____ Schedule _____
Attach additional pages for more medications.

PHYSICIAN:

Name of family physician _____ Phone ( ) _____
Address _____

PERMISSION TO PROVIDE NECESSARY TREATMENT OR EMERGENCY CARE:

In signing this form 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 listed above. In the event they cannot be reached I hereby give permission to the medical personnel selected by the camp director to secure and administer treatment including hospitalization and to provide or arrange necessary related transportation for me. I agree to the release of any records necessary for insurance purposes.

Signature of Adult camper/staff _____ **Date** _____