Camper Health Form

Victory Bible Camp
64741 S Victory Rd
Sutton, AK 99645
Ph: (907) 745-4203
Fax: (907) 745

Emergency/Alternate Contacts

Camper's Name _____ DOB _____ Sex: M F Age _____
Address _____City _____ State _____ Zip _____
Parent 1 Name (custodial parent or guardian) _____
Home (____) _____ Work (____) _____ Cell (____) _____
Parent 2 Name _____
Home (____) _____ Work (____) _____ Cell (____) _____
Where can you be reached during camp?_____
(If you plan to be out of town, please attach your itinerary and contact numbers)
Medical Insurance Company _____ Policy Number_____
Name of Camper's Physician _____ Phone _____
Physician's Clinic and Address _____
In case we cannot reach you, please list two relatives or friends whom you authorize to act on your behalf, including health care decisions:
Name _____ Phone (____) _____ Work (____) _____
Name _____ Phone (____) _____ Work (____) _____

Is there anyone in particular to whom your child must NOT be released or we should be concerned about? **NO YES**

If yes – Name _____ Relationship to camper _____

Immunization History

Please list dates for all of the following immunizations: EXACT DATES ARE REQUIRED – *Please do not write "Up to Date"*

Vaccine:	Mo/Yr	Mo/Yr	Mo/Yr
DTaP (diphtheria, tetanus, acellular pertussis			
Tdap (adolescent/adult prep)			
TB			
OPV/IPV (polio)			
MMR (measles, mumps, rubella)			
HepB (Hepatitis B)			
Hib (Haemophilus Influenza B)			
Varicella (chickenpox)			

Current Medications

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last ONLY the week at camp. All drugs *must* remain in **ORIGINAL PACKAGING** that identifies the camper, prescribing physician (if prescription drug), the name of the medication, the dosage and the frequency of administration. Loose pills and/or expired medications will NOT be accepted or administered. ALL INHALERS AND EPI PENS NEED TO BE IN ORIGINAL BOX WITH PRESCRIPTION LABEL. Vitamins and other supplements will not be accepted.

PLEASE CIRCLE MEDICATION TIMES(S):

Med #1 _____ Dosage _____ Bkfst Lunch Dinner Bedtime
Reason for Taking _____

Med #2 _____ Dosage _____ Bkfst Lunch Dinner Bedtime
Reason for Taking _____

Med #3 _____ Dosage _____ Bkfst Lunch Dinner Bedtime
Reason for Taking _____

Over the counter Medications

Victory offers the following non-prescription medications on an as-needed basis. By law we must use our own supply. By signing this form, you give your permission to administer these medications to your child. Please CHECK any medications you **DO NOT** want our Health Center to give to your child.

☐ Acetaminophen (Tylenol) ☐ Ibuprofen (Advil) ☐ Triple antibiotic ointment ☐ Throat Spray
☐ Hydrogen peroxide ☐ Dimetapp ☐ Hydrocortisone cream 1% ☐ Calamine lotion
☐ Benadryl ☐ Cough medicine ☐ Bismuth tablets (Pepto Bismol) ☐ Visine
☐ Sudafed

Allergies and Allergic Reactions

Please list all known allergies and describe reaction and management of the reaction:

Medication Allergies	Reaction and management (ingestion, inhalation or contact)
_____	_____
_____	_____
Food Allergies	**Reaction and management (ingestion, inhalation or contact)**
_____	_____
_____	_____
Other Allergies (plants, insects, chemicals, etc.)	**Reaction and management (ingestion, inhalation or contact)**
_____	_____
_____	_____

Mental, Emotional and Social Health – check all that apply:

☐ Attention Deficit Disorder (ADD) ☐ ADHD ☐ Hyperactivity ☐ Learning disability ☐ Emotional health concern

General Health Questions

Yes No

☐ ☐ 1. Had any recent injury, illness or infectious disease or a chronic recurring illness/condition?
☐ ☐ 2. Ever been hospitalized or had surgery?
☐ ☐ 3. Have frequent headaches? Migraines? Ever had a head injury?
☐ ☐ 4. Ever suffered with convulsions/seizures?
☐ ☐ 5. Does the child suffer from diabetes?
☐ ☐ 6. Wear glasses, contacts or protective eye wear?
☐ ☐ 7. Ever had frequent ear infections?
☐ ☐ 8. Ever passed out or been dizzy during or after exercise?
☐ ☐ 9. Ever had back problems or problems with joints (knees, ankles, wrists, shoulders)?
☐ ☐ 10. Have an orthodontic appliance being brought to camp?
☐ ☐ 11. Have any skin problems (e.g. itching, rash, acne)?
☐ ☐ 12. Have problems sleepwalking or bed wetting?
☐ ☐ 13. Does the child have piercings? If so, where?

Please indicate the question number and explain any “yes” answers. You many use an additional sheet of paper.

_____

_____

_____

Describe any restrictions to your camper’s activities while at camp.

_____

_____

_____

PERMISSION TO TREAT

Camper Name:

_____

I attest that my child is in good health and able to actively participate in camp activities except as noted on this form. I take full responsibility to see that my child is properly prepared for camp including having proper clothes and equipment and being in good health.

I authorize the camp to provide routine health care, administer prescribed and over-the-counter medications for various problems. I authorize the camp to share information in this Health Form with selected camp staff (counselor, health care & inclusion staff) and professional health care providers on a need-to-know basis.

In the event I cannot be reached in an emergency, I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests, treatments; to release any records necessary for insurance purposes; to provide/arrange necessary transportation for my child. I give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child.

Signature of Parent/Guardian _____ Relationship _____

Date_____