Agapé ✞ Kure Beach Ministries Health History Form

To Parent(s)/Guardian(s): Please follow the instructions below.
Attach additional information if needed.

1. ***Complete front and back of this form and make a copy.***
2. ***Send the <u>original</u> signed form to camp at least 10 days prior to camper's arrival.***
3. ***Campers cannot be accepted for camp sessions without a signed health history.***

Mail this form to:

Agapé ✞ Kure Beach Ministries
1369 Tyler Dewar Lane
Fuquay-Varina, NC 27526

Camper Name: _____
Last First Init.

☐ Male ☐ Female Birth Date _____ Grade Entering: _____ Dates will attend camp: from _____ to _____
Month/Day/Year Month/Day/Year Month/Day/Year

Camper Email: _____ Camp Program _____

Camper Home Address: _____
Street Address City State Zip Code

<u>Parent/guardian with legal custody to be contacted in case of illness or injury:</u>

Name: _____ Relationship to Camper: _____

Home Phone: (_____)_____ Cell Phone:(_____)_____ Email: _____

Home Address: _____
(If different from above) Street Address City State Zip Code

<u>Second parent/guardian or other emergency contact:</u>

Name: _____ Relationship to Camper: _____

Home Phone: (_____)_____ Cell Phone:(_____)_____ Email: _____

<u>Additional contact in event parent(s) (guardian(s) can not be reached:</u>

Name: _____ Relationship to Camper: _____ Home/Cell Phones: (_____)_____(_____)_____

<u>Allergies</u>: ☐ No known allergies. ☐ This camper is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other
(Please describe below what the camper is allergic to and the reaction seen.)

<u>Diet, Nutrition</u>: ☐ This camper eats a regular diet. ☐ This camper eats a regular vegetarian diet.
☐ This camper has special food needs. ***(Please describe below.)***

<u>Activity Restrictions:</u> Chronic illness, operations, or serious injury. ***(Please describe below.)***

<u>General Health History</u>: ***Check "Yes" or "No" for each statement. Explain "Yes" answers below.***

Has/does the camper:

1. Had frequent ear infections?	☐ Yes	☐ No	12. Had mononucleosis ("mono") during the past 12 months?	☐ Yes	☐ No
2. Have a heart defect or heart disease?	☐ Yes	☐ No	13. If female, have problems with periods/menstruation	☐ Yes	☐ No
3. Had seizures or convulsions?	☐ Yes	☐ No	14. If female, has been told about menstruation?	☐ Yes	☐ No
4. Have a bleeding/clotting disorder?	☐ Yes	☐ No	14. Have problems with falling asleep/sleepwalking?	☐ Yes	☐ No
5. Had a recent injury?	☐ Yes	☐ No	15. Had hypertension?	☐ Yes	☐ No
6. Have asthma/wheezing/shortness of breath?	☐ Yes	☐ No	16. Have a history of bedwetting?	☐ Yes	☐ No
7. Have diabetes?	☐ Yes	☐ No	17. Had Chicken Pox?	☐ Yes	☐ No
8. Had Psychiatric Treatment?	☐ Yes	☐ No	18. Had Measles?	☐ Yes	☐ No
9. Have headaches?	☐ Yes	☐ No	19. Had Mumps?.	☐ Yes	☐ No
10. Wear glasses, contacts, or protective eyewear?	☐ Yes	☐ No	20. Had German Measles?	☐ Yes	☐ No
11. Have diabetes? (year) _____	☐ Yes	☐No			

***Please explain "Yes" answers in the space below*,** noting the number of the questions.

Camper Name Last First Initial
(For Camp Use) Cabin or Group _____
(For Camp Use) Week/Camp _____

Camper Health History Form
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Camper Name: _____
Last First Init.

Mental, Emotional, and Social Health: *Check "Yes" or "No" for each statement.*

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ☐ Yes ☐ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? ☐ Yes ☐ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? ☐ Yes ☐ No
4. Had a significant life event that continues to affect the camper's life? (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others) ☐ Yes ☐ No

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Immunization Record:

Date of Last Tetanus _____ DPT _____ Polio _____ MMR _____

If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent/Guardian: _____ Date: _____ Relationship to Camper: _____

Medication: ☐ This camper will not take any daily medications while attending camp.
☐ This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies.
Please review camp instructions about required packaging/containers. Many states require original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.

Name of Medication	Date Started	Reason for taking it	When it is given	Amount or dose given	How it is given
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time: _____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time: _____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time: _____		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. ***Cross out those the camper should not be given.***

Acetaminophen (Tylenol)
Ibuprofen (Advil, Motrin)
Antihistamine/allergy medicine
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Calcium Carbonate (Tums, Antacid tablets)
Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)
Phenylephrine decongestant (Sudafed PE)
Pseudoephedrine decongestant (Sudafed)
Guaifenesin cough syrup (Robitussin)
Dextromethorphan cough syrup (Robitussin DM)
Generic cough drops
Sore throat spray
Calamine lotion
Antibiotic cream
Aloe
Bandaid Anti-Itch Gel (.45% camphor)
Isotonic Solution (eyedrops)
Isopropyl Alcohol (ear drops for swimmer's ear)

Health-Care Providers:

Name of camper's primary doctor(s): Phone: ( )

Medical Insurance Information: This camper is covered by family medical/hospital insurance ☐ Yes ☐ No

Please include a copy of your insurance card; copy both sides of the card so information is readable.

Insurance Company_____ Policy or ID #_____ Group Plan # _____

Subscriber_____ Insurance Company Phone Number (_____)_____ Where insured is employed _____

Address for claims _____

Check here ☐ if you do NOT give permission for A✝KB Ministries to photograph your child for camp promotional purposes (brochures, SmugMug, etc.) **No names are used.**

Parent/Guardian Authorization for 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 my child 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 child. 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 my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian _____ Date:_____ Relationship to Camper: _____

What Have We Forgotten to Ask?

Please attach any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program.