Mt. Cross Ministries
CAMPER HEALTH HISTORY FORM

Mail this form to the address below
2 weeks before arrival

Mt. Cross Ministries
PO Box 387
Felton, CA 9501

Camper Name: _____
First Middle Last

Dates will attend camp: from _____ to _____
Month/Day/Year Month/Day/Year

☐Male ☐Female Birth Date _____ Age on arrival at camp: _____
Month/Day/Year

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

1) **Complete pages 1, 2 and 3 of this form and make a copy.**
2) **Send the original, signed FORM to camp no later than 2 weeks prior to arrival.**

Camper Home Address: _____
Street Address City State Zip Code

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

Name: _____ Relationship to Camper: _____ Preferred Phones: (_____) _____ (_____) _____

Email: _____

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

Second parent/guardian or other emergency contact:

Name: _____ Relationship to Camper: _____ Preferred Phones: (_____) _____ (_____) _____

Email: _____

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

Name(s): _____ Relationship to Camper: _____ Preferred Phones: (_____) _____ (_____) _____

Allergies: ☐ 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 their reaction.)

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

Restrictions: ☐ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
☐ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or considerations. ***(Please describe below.)***

Medical Insurance Information:

This camper is covered by medical/hospital insurance ☐ Yes ☐ No

Include a copy of camper's insurance card; copy both sides of the card so information is readable.

Insurance Company _____ Policy Number _____

Subscriber _____ Insurance Company Phone Number (_____) _____

Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person identified 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 and urgent 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 camper. 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 this camper's health record from providers who treat the camper and these providers may talk with the program's staff about camper's health status.

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

Camper Name First Middle Last (For Camp Use) Cabin or Group _____ (For Camp Use) Dates Attenting: _____

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Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

Immunization History:
Is the camper current on all immunizations needed for school? ☐ Yes ☐ No Date of last Tetanus:_____

Please submit a copy of your child's immunization record with this form.

If you/your camper has not been fully immunized, your signature **acknowledges that you understand and accept the risks to you/your child from not being fully immunized**.

Signature of Custodial Parent/Guardian OR adult camper: _____ 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.

It is required to have 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 & Dose	Reason for taking	When it is given
		☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:_____
		☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:_____
		☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:_____
		☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:_____

Specific non-prescription medications are stocked in the camp Health Center and are used on an as needed basis to manage basic illness and injury based upon physician reviewed and approved policy and procedures.

- We ask that you **DO NOT SEND** commonly used over-the-counter medications if your camper takes them only on an ***occasional basis***. We have many medications on site and can provide them for your camper as needed.
- If your camper takes an over-the-counter medication or vitamin on a **DAILY** basis, you must bring them in the original containers, clearly labeled with the camper's name and specific directions for administration.

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

Has/does the camper:

1. Ever been hospitalized?	☐ Yes	☐ No	11. Had fainting or dizziness?	☐ Yes	☐ No
2. Ever had surgery?	☐ Yes	☐ No	12. Passed out/had chest pain during exercise?	☐ Yes	☐ No
3. Have recurrent/chronic illnesses?	☐ Yes	☐ No	13. Had mononucleosis ("mono") during the past 12 months?	☐ Yes	☐ No
4. Had a recent infectious disease?	☐ Yes	☐ No	14. If female, have problems with periods/menstruation?	☐ Yes	☐ No
5. Had a recent injury?	☐ Yes	☐ No	15. Have problems with falling asleep/sleepwalking?	☐ Yes	☐ No
6. Had asthma/wheezing/shortness of breath?	☐ Yes	☐ No	16. Ever had back/joint problems?	☐ Yes	☐ No
7. Have diabetes?	☐ Yes	☐ No	17. Have a history of bedwetting?	☐ Yes	☐ No
8. Had seizures?	☐ Yes	☐ No	18. Have problems with diarrhea/constipation?	☐ Yes	☐ No
9. Had headaches?	☐ Yes	☐ No	19. Have any skin problems?	☐ Yes	☐ No
10. Wear glasses, contacts, or protective eyewear?	☐ Yes	☐ No	20. Traveled outside the country in the past 9 months?	☐ Yes	☐ No

Please explain "Yes" answers in the space below, noting the number of the questions and estimate of diagnosis and/or concern. The camp may contact you for additional information.

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Camper Name: _____
First Middle Last
Birth Date: _____
Month/Day/Year

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. In the past 12 months, seen a professional to address mental or emotional health concerns?..... ☐ Yes ☐ No
4. Had a significant life event that continues to affect the camper's life?..... ☐ Yes ☐ No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, etc.)
5. Does this camper have any current mental or psychological conditions requiring special restrictions or considerations while at camp?..... ☐ Yes ☐ No

Please explain "Yes" answers in the space below, noting the number of the questions and estimate date of diagnosis and/or concern. The camp may contact you for additional information.

Health-Care Providers:

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

Name of dentist(s): _____ Phone: (_____) _____

Name of orthodontist(s): _____ Phone: (_____) _____

What Have We Forgotten to Ask? ***Please provide in the space below*** 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. ***Attach additional information if needed.***

Parents/Guardians: STOP here. The rest of this is form is completed when the camper arrives at camp. Keep a copy for your records.

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Camper Name: _____
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Birth Date: _____
Month/Day/Year

Individual Health Record *(For Camp Use Only)*

Initial Screening: Date: _____ Signature: _____ Initials: _____

☐ Screening has been conducted according to camp protocol and significant findings noted as follows:

A.	Any signs/symptoms of illness or injury upon arrival?	☐ No	☐ Yes, as noted below
B.	Has the camper had any symptoms of nausea, vomiting, diarrhea or fever within the last week? ……..…	☐ No	☐ Yes, as noted below
C.	Does the camper have symptoms of lice or pink eye? ……..	☐ No	☐ Yes, as noted below
D.	Has the camper had a rash in the last two weeks? ……..……	☐ No	☐ Yes, as noted below
E.	Has the camper had a cough, sore throat, or headache in the last two weeks? ……...	☐ No	☐ Yes, as noted below
F.	Has the camper been exposed to family members or roommates with any of the symptoms or illnesses listed above? …….	☐ No	☐ Yes, as noted below
G.	Medication given to healthcare staff? …….	☐ No	☐ Yes, as noted below

Screening Notes:

Exit Note: Check one of the following:

☐ Left camp this day with no reported illness or injury symptoms ☐ Left camp this day with the following problem/concern:

Date/Time: _____ Name: _____ Initials: _____