Episcopal Church Camp of Illinois
Health History Form

This completed form (front and back) **must** be sent to the address listed below to ensure your spot at camp.

Registrar Use Only
J M S

Cabin _____

Balance Due_____

CAMPER/PARTICIPANT/FAMILY INFO:

Camper Name: _____ Birthdate:_____/_____/_____
Last First MI

Gender: M F Age at time of camp: _____ Mailing Address: _____
Street Address City State Zip

Parent or Guardian (if under 18): _____ Primary Phone: (____) _____

Address (if different from above): _____
Street Address City State Zip

Work Phone: (____) _____ Cell Phone: (_____) _____

EMERGENCY CONTACT:

Contact the following person in an emergency if parent or guardian above is not available:

Name:_____ Relation to camper: _____
Last First

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

HEALTH HISTORY:

Physician Name: _____ Address/Phone _____ (____) _____
Street City State Zip Phone

Please list allergies, and describe the severity of allergic reactions and circumstances that may contribute to them:

Medications: _____

Food allergies:_____

Other allergies:_____

Dietary restrictions (due to medical conditions): _____

Describe any medical, psychological, emotional, or behavioral conditions the camp staff needs to know about in order to support and protect the welfare of your camper, to enable him/her to participate fully in the camp program, and to receive appropriate emergency care. (e.g., asthma, seizures, bed-wetting, menstrual issues, ADD/ADHD, autism, diabetes, etc.)

_____

_____

_____

_____

Describe preferred response if issues with these conditions arise. Attach an additional page if needed _____

_____

_____

Please list any activities in which the camper should NOT participate for health reasons _____

_____

Please list any surgeries _____

If the camper takes prescribed or over-the-counter medications, please list them here (or attach an additional page):_____

_____

NOTE: Any prescriptions to be administered at camp MUST be sent in their prescription bottles

Is camper current on all immunizations as required by the public school system? □ Yes □ No Date of last Tetanus shot: ___/____/_____

For female campers: Has this person menstruated? **Y N** If not, has she been told about it? **Y N**

Please complete the other side of this form

Revised 1/17

PERMISSION TO ADMINISTER MEDICATIONS:

I, the (parent of/guardian of/camp participant) Please circle which

_____, give permission to the camp Health Care Provider or his/her designate to give the following over-the-counter medications (or the generic equivalents) to the camper listed above, in accordance with recommended package dosing for the specific indications below. These medications are available at camp and need not be brought by participants.

	Yes	No
Tylenol: Mild fever or discomforts		
Ibuprofen: Mild fever or discomforts		
Throat Lozenges: Coughs/sore throat		
Topical Creams: Itching, sunburn, or insect bites		

	Yes	No
Benadryl: Allergy symptoms		
Sudafed: Allergy symptoms		
Antacid: Upset stomach		
Anti-diarrheal: For diarrhea		

Permission to follow recommendations by local poison control centers		

Signature of Parent/Guardian/Self: _____ Date:_____/_____/_____

Note: The camp personnel will notify you or the emergency contact if you or your child displays the following symptoms:

- Any illness that persists longer than 24 hours; including fevers, coughs, excess expulsion of bodily fluids, allergic reactions, severe tiredness.
- Any injury that causes severe prolonged pain, discoloration and/or swelling.
- Any condition that cannot be sufficiently treated by camp personnel.
- Any condition requiring transportation to other medical services.

FAMILY MEDICAL INSURANCE:

Family Medical Insurance □ Yes □ No Name of Policyholder: _____
Individual's First and Last Name

Company/Guarantor: _____ Group Number:_____ Policy Number:_____

***NOTE**: Some emergency rooms ask for the parent's Social Security Number. It is not required that this information be provided to ECC, but you may be asked by the hospital to provide it before they will treat your camper.*

PARENT/GUARDIAN/PARTICIPANT AUTHORIZATION:

I, _____ represent that the above information is correct for either me or my child. I or my child has permission to take part in all camp activities under supervision unless limitations are noted above, and I agree that the camp or camp personnel will not be held responsible for accidents arising therefrom. I hereby give permission to the camp to provide medical health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me or my child. In the event of an emergency: (for child) if I cannot be reached, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, injection, surgery and anesthesia for the person named above; (for myself) and in which I am incapacitated and/or the emergency contact cannot be reached, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, injection, surgery and anesthesia for the person named above. This completed health form may be photocopied for trips out of camp. My signature below represents that the above information on this form is correct for the camper listed.

Signature of Parent/Guardian: _____ Date: _____

Episcopal Church Camp of Illinois
C/O Katrina Honnold
381 S River Run Dr
Hogansville, GA 30230