

## Checkpoint Bible Camp Health Record

This form must be submitted by all campers and staff under 18 yrs. old.  
Please complete this form within 24 hours prior to camper or staff arrival.

**DO NOT MAIL THIS FORM**

Camper/Staff Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Age \_\_\_\_\_ Circle: Male Female

Church Name \_\_\_\_\_ Church City \_\_\_\_\_

Parent/Guardian Names \_\_\_\_\_

Cell Phone: Father \_\_\_\_\_ Mother \_\_\_\_\_

Insurance: \_\_\_\_\_ Yes \_\_\_\_\_ No Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_ Please attach a photocopy of both sides of insurance card.

In case of Emergency, please notify \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Other Emergency contacts & Phone numbers \_\_\_\_\_

### Health History

Are you now, or have you ever been treated for any of the following.  
If so, please explain below.

YES	NO	Condition
		Asthma Last attack:
		Diabetes
		Hypertension (High Blood Pressure)
		Heart Condition
		Lung/Respiratory Disease
		Ear/Sinus Problems
		Muscular/Skeletal condition
		Psychiatric/psychological and emotional difficulties
		Behavioral disorders (e.g. ADD, ADHD, Asperger syndrome, autism)
		Bleeding disorder
		Fainting spells
		Thyroid disease
		Kidney disease
		Sickle cell disease
		Seizures Last seizure:
		Abdominal/digestive problem
		Surgery
		Serious Injury
		Other

### Immunizations

Tetanus required and must have been received within the last 10 years. If had the disease please put a "D" in the date column.

Yes	No	Type	Date series completed
		Tetanus	
		Pertussis	
		Diphtheria	
		Measles	
		Mumps	
		Rubella	
		Polio	
		Chicken Pox	
		Hepatitis A	
		Hepatitis B	
		Influenza	
		Meningococcal (Meningitis)	
		Other	

Explanation: \_\_\_\_\_

### Non-Prescription Medications

The following non-prescription medications may be administered to your child, if needed, while at camp.

- *Generic equivalent may be substituted for the name brand medications.*
- *All medications will be given according to label instruction based on age/weight unless otherwise instructed by parent or guardian.*

	Yes	No
Tylenol		
Advil/Motrin		
Benadryl		
Robitussin		
Pepto-Bismol		
Tums		
Additional Instructions:		

### Allergies or Reactions to:

	Yes	No	Explain
Food			
Plants			
Insect Bites			
Medication			
Other			

### Prescription Medications

Parents or guardians please list your child's prescription medications, vitamins, herbs and or dietary supplements, as ordered by the child's physician.

- *All medications will be given as directed on prescription containers. Explain any differences in instructions.*

Medication Name	Dosage	Frequency & Indications	Reason for Medication

Comments:

All medications must be in their original containers. Place all medication containers in a zip-lock bag with this completed form detailing instructions for the use of each medication your child is to receive at camp. A medical attendant will receive medications at the First Aid Station during camp check-in. Inhalers & Epi-pens are the only medications that can be kept with the campers. (Please send two in case one is lost; one will be checked in with the nurse.) **NO PRESCRIPTION MEDICATIONS CAN BE ADMINISTERED UNLESS LISTED ON THIS FORM WITH PARENT OR LEGAL GUARDIAN SIGNATURE.** All camper medications must be administered by medical attending personnel.

I, \_\_\_\_\_, Parent or Legal Guardian of \_\_\_\_\_  
(camper or staff name)

Authorize the camp medical personnel to administer the medication listed above. I give my permission to release information to designated leader with my child during this week of camp. I authorize the Camp Executive Staff to consent to medical treatment when either I or my assignee cannot be contacted. I understand that every effort will be made to contact me before such action.

Copies: A photocopy or electronic reproduction of this signed authorization may be considered valid.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Date must be 24 hours prior to camp)