UNITED 4 KIDZ CAMP
Health Form

<u>Every section</u> must be completed by a parent/guardian, signed, and turned in by July 14th.

CHILD'S INFORMATION

Name ______________________________

Address ______________________________

City ______________________________

State ____________ Zip ____________

Grade *(in the fall)* ______________________________

Birth Date _____ / _____ / _____ Male Female

PARENT/GUARDIAN INFORMATION

Name ______________________________

Cell Phone (______)______________________________

Other Phone (______)______________________________

Email ______________________________

Relationship to Child ______________________________

Address *(if different)* ______________________________

City/State/Zip ______________________________

ALTERNATIVE EMERGENCY CONTACT INFORMATION

Name ______________________________

Cell Phone (______)______________________________

Address ______________________________

City ______________________________

State ____________ Zip ____________

Relationship to Child ______________________________

Name ______________________________

Cell Phone (______)______________________________

Address ______________________________

City ______________________________

State ____________ Zip ____________

Relationship to Child ______________________________

PICK-UP AUTHORIZATION

List the individuals that are authorized to pick up your child from camp.

Name ______________________________

Phone (______)______________________________

Name ______________________________

Phone (______)______________________________

Name ______________________________

Phone (______)______________________________

Anyone who is NOT allowed contact with your child:

____

PHOTOGRAPHY RELEASE

I, ____________________, the parent or legal guardian
(your name)

of ____________________ grant Faith Community
(child's name)
Church my permission to use the photographs and videos from Kidz Camp for any legal use, including but not limited to the promotion of camp.

OR

I Do NOT give permission for my child's photos to be used in this way.

PHYSICIAN & INSURANCE

Physician's Name ______________________________

Address ______________________________

City/State/Zip ______________________________

Phone (_______)______________________________

Insurance Provider ______________________________

Policy Holder's Name ______________________________

Policy Number ______________________________

In the event that there is no insurance coverage I (Parent/Guardian) will be responsible for all medical costs.

Signature ______________________________

Date _____ /_____ / ______

ALLERGY INFORMATION

Please describe any known allergies your child has and explain treatments thoroughly. If your child has severe food allergies or special dietary needs, please contact your camp representative to discuss child's needs. Gluten free meal options available for a $30 cost and dairy free for $21.

Allergy ______________________________

Reaction ______________________________

Treatment ______________________________

____

Allergy ______________________________

Reaction ______________________________

Treatment ______________________________

____

Allergy ______________________________

Reaction ______________________________

Treatment ______________________________

____

ILLNESS/IMUNIZATIONS

Is your child up to date on the following vaccines?

Measles/MMR: Yes No

Tetanus (DTP, DTap, DT, or Td): Yes No

Chicken Pox (Varicella): Yes No

Meningococcal (MCV4 or MPSV4): Yes No

MEDICATION INFORMATION

All medications (prescription or not) **must be in its original container.** Prescription medication (including inhalers) must have original pharmacy label indicating camper's name, prescribing doctor, and dosage instructions. Have medications ready to be turned in to Camp Nurse during the registration process. List all medications your child will bring to camp (including over-the-counter, inhalers, and epi pens).

Medication ______________________________

Reason ______________________________

Dosage ____________ Hours Given ______________

Medication ______________________________

Reason ______________________________

Dosage ____________ Hours Given ______________

Medication ______________________________

Reason ______________________________

Dosage ____________ Hours Given ______________

Medication ______________________________

Reason ______________________________

Dosage ____________ Hours Given ______________

Medication ______________________________

Reason ______________________________

Dosage ____________ Hours Given ______________

HEALTH HISTORY

Please indicate if your child has any of the following:

- Diabetes
- Heart Condition
- Bed-Wetting
- Hearing Problems
- Glasses/Contacts
- Kidney Problems
- Digestive Issues
- Frequent Ear Infections
- Mononucleosis
- Frequent Headaches

Asthma- Describe severity and treatment:

____

____

Recent Injuries, Illnesses, or Infectious Diseases:

____

____

Seizures- List type and date of last occurrence:

____

____

For your child's safety, if your child has had seizure activity in the last 12 months or is currently on seizure medication, a written statement and signature from the treating physician is required. This statement must be on the physician's letterhead, clearly stating that your child is physically able to participate in all camp activities.

Is your child under the care of a Social Worker, Psychologist, Behavioral Therapist, or any other

ADDITIONAL CONCERNS

Describe any additional health or behavioral needs your child has that we should be aware of while caring for you child: ____________________________

____

____

____

____

____

____

____

POLICIES

Head Lice/Nits:
Please check your child for lice before camp. An inspection will be completed during registration. **If your child is found to have lice, your child will NOT be permitted to stay at camp** for their safety. If there should be an incident of lice at camp you will be notified and you will need to pick up your child immediately so that proper treatment can be provided.

Behavior:
We understand that a week at camp may be a new experience for your child. If your child is continually disruptive and disrespectful and we have taken several steps to redirect the behavior, we will contact you to pick up your child.

AUTHORIZATIONS

Medical:
I hereby give permission to the authorized camp staff to provide routine 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 insurance purposes. I give permission to the camp to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the authorized camp staff to secure and administer treatment, including hospitalization, for the child named on this form.

Signature ________________________________

Date _____ /_____ / ______

Participation:
My child has permission to engage in all camp activities except as noted. The information provided on this form is accurate to the best of my knowledge. I have indicated any special health conditions, including required medication and activity limitations which should be known to the Camp Nurse and Staff. I have read through all of the information provided and agree to the requirements stated. I am aware of and accept the risk inherent in the camp program.

Signature ________________________________

Date _____ /_____ / ______

This page is intentionally left blank for parent/guardian to provide additional information if needed.

CAMP COUNSELOR INFORMATION

This page will be given to your child's counselors. To ensure that your child receives the care and attention needed, PLEASE complete the following information thoroughly.

BASIC & SAFETY INFORMATION

Name ______________________________________ Grade *(in the fall)* _____________________________

Birth Date _____ / _____ / _____ Male Female

Disabilities/Disorders or Medical Needs (ADHD, Depression, Asthma, etc.) _______________________________

____

Food or Activity Restrictions: ____

____

Anyone That is Legally Restricted from Contacting your Child: ____

GETTING TO KNOW YOUR CHILD

Has your child been away from home more than two days? Yes No

Sleep Habits: Light Sleeper Deep Sleeper Sleepwalker Bed-Wetter Nightmares

Is your child *(check all that apply)* ...

Morning Person
Night Owl
Quick at Making Friends
Takes Time Making Friends
Assertive with Their Needs
Goes with the Flow
Independent
Team Focused
Creative
Sporty
Optimistic
Realistic
Extroverted
Introverted
Listener
Talker
Leader
Follower
Takes Initiative
Needs Step-by-Step Guidance
Slow Processor

What experiences would you like your child to have at camp? ____

____

What are your child's strengths? ____

____

What are your child's struggles? ____

____

What are your child's triggers? ____

____

What are ways that we can help your child if they become upset, anxious, or overstimulated? _______________

____

____

What other information would you like the Senior Camp Counselor to know to help your child adjust to camp?

____

____