

Date _____

Camper Name: LAST, FIRST (Please print)

Medical Form

Medical information must be provided for you or your child to attend camp. To ensure the health and safety of our volunteer staff, adult and youth participants in Ohio Conference UCC programs, we ask that you provide health information, including health insurance information. Please disclose all health history and information as completely and thoroughly as possible. It is essential for the camp to have all participants' current health information, in order to be able to ensure the safety and well-being of campers during their time at camp.

Date of Birth: _____ Age: _____ Gender _____

Household

Parent Name (for minors) _____

Address: _____
Street City State Zip

Email _____ Phone _____

Emergency Contact Information

Name _____ Relationship _____

Phone: Home _____ Work _____ Cell _____

General Information

Height _____ (Feet and inches) Weight _____ (Lbs) Last exam date _____

Allergies and Dietary Restrictions

Does the camper require an EpiPen? Yes No

If yes, please provide details about the camper's anaphylaxis, including the date and description of the reaction.
If the camper requires an EpiPen, please provide one non-expired EpiPen for the camper to carry with them.

Does the camper have any allergies (food, drug or environmental)?

Allergen	Allergic reaction details, date, and description

Does the camper have any dietary restrictions (vegan, vegetarian, gluten-free, other)? Please explain.

Medications and Treatments

Will the camper be taking any medications while at camp? Medicine must be brought to camp in its original packaging.

Medication Name	Dose	Schedule Times taken each day (circle below)	Details: Please explain the reason for the medication and any notes on giving this medication to the camper.
		Breakfast Lunch Snack Dinner Before Bed As Needed	
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		Breakfast Lunch Snack Dinner Before Bed As Needed	

Over the Counter Medication

The following non-prescription medications are stocked in Junior and Adult forms by the camp and are used on an as-needed basis to manage illness and injury. May the following medications be given to the camper while at camp?

Medication Name	Allowed?	
Acetaminophen (Tylenol)	Yes	No
Antihistamines/allergy medicine	Yes	No
Calamine Lotion	Yes	No
Calcium carbonate (Tums)	Yes	No
Generic cough drops	Yes	No
Hydrocortisone cream	Yes	No
Ibuprofen (Advil)	Yes	No
Triple Antibiotic Ointment	Yes	No

Is there anything the camp needs to be aware of when giving any of the approved over-the-counter medications to the camper?

Will the camper require any treatments while at camp? If so, please explain what treatments must be given, including the frequency.

Does the camper regularly take any medications that will not be taken at camp? If so, please explain what medications are taken and why.

Immunizations

Please list the date of the camper’s most recent vaccination or booster, if any, for the following:

Vaccination	Vaccinated?		Date(s)
Chicken Pox (Varicella)	Yes	No	
Diphtheria, Pertussis, Tetanus, Polio	Yes	No	
Tetanus Booster	Yes	No	
Haemophilus Influenza B	Yes	No	
MMR	Yes	No	

If the camper has not been fully immunized, please explain.

Health History

Has the camper experienced, or is currently experiencing, any of the following conditions? Be sure to fully explain any conditions the camper is currently experiencing.

Condition			Details
ADD/ADHD/Behavioral Issues	Yes	No	
Asthma/Inhaler	Yes	No	Is the condition mild, moderate or severe; is it sports induced?
Back/Neck Pain or Injury	Yes	No	
Bedwetting/Nightmares/Terrors	Yes	No	
Blackouts/Fainting	Yes	No	
Bleeding Disorder	Yes	No	
Cancer	Yes	No	
Chest pain/Heart disease	Yes	No	
Concussion	Yes	No	

Constipation/Diarrhea/Crohn's	Yes	No	
Dental Braces, Caps or Bridges	Yes	No	
Depression	Yes	No	
Developmental Delays	Yes	No	
Diabetes	Yes	No	Date of diagnosis and required care
Eating Disorder	Yes	No	
Excessive weight gain/loss	Yes	No	
Hay Fever	Yes	No	
Headaches (frequent)	Yes	No	
Hearing problems	Yes	No	
High Blood Pressure	Yes	No	
Kidney Disease	Yes	No	
Menstrual Difficulties	Yes	No	
Mental Health Issues	Yes	No	
Problems Breathing or Coughing	Yes	No	
Seizures	Yes	No	
Skin Problems	Yes	No	
Sleepwalking	Yes	No	
Speech Problems	Yes	No	
Ulcer	Yes	No	
Urinary Tract Infection	Yes	No	
Uses eye glasses or contacts	Yes	No	
Other	Yes	No	

Disease History

Has the camper had or currently has any of the following diseases? Be sure to fully explain any disease(s) the camper currently has.

Disease	Yes	No	Details
Chicken Pox (Varicella)	Yes	No	
Measles (German)	Yes	No	
Measles (Red)	Yes	No	
Mono (past 1 year)	Yes	No	
Mumps	Yes	No	
Rheumatic Fever	Yes	No	
Scarlet Fever	Yes	No	
Whooping Cough	Yes	No	

Has the camper had any operations? If so, please explain, including dates. It is important to note if prior operation(s) will affect the camper's health while at camp.

Has the camper ever been hospitalized or had a serious injury? If so, please explain the reason(s) for the hospitalization(s) or the serious injury(ies) and the dates they occurred. It is important to mention any signs of illness that camp staff should look out for.

Has the camper been exposed to any communicable diseases within the last 3 months? If so, explain the diseases and when the exposure occurred.

Does the camper have any restrictions on activity? If so, please explain what activities must be restricted, and list any special accommodations that should be made.

Will the camper require any special assistance while at camp? If so, please explain what assistance will be required.

Is there anything you would like to discuss with the camp medical staff? If so, please explain.

Please list any other medical information the camp should have about the camper.

Doctor Information

Family Doctor _____ Phone _____

Family Dentist _____ Phone _____

Health Insurance

Do you have medical insurance? ____ Yes ____ No

Full Name of Policy Holder _____ Phone _____

Employer Name (if insured through company) _____

Insurance Company / Plan Name _____ Phone _____

Health Insurance Policy Number _____ Insurance Group Name or Number _____

Authorization for Treatment

The information on this form is correct and complete so far as I know. The participant has permission to participate in all activities except those noted.

I hereby give permission for the Ohio Conference UCC Outdoor Ministries program staff to administer the above-mentioned over-the-counter medications if the camp health professional deems it necessary. Dosages will be administered according to directions on the bottle unless a physician directs otherwise.

I hereby give permission to Ohio Conference UCC staff and designees to transport the participant named on this form to an Emergency Room, and in the same event I also give permission to the physician selected or assigned to order X-rays, routine tests, treatment related to the health of the participant for both routine health care and in emergency situations.

If I cannot be reached in an emergency, or if my emergency contact cannot be reached, I give my permission to the physician for any of the following actions as it pertains to the participant named above: hospitalization, securing proper treatment, or ordering injection, anesthesia or surgery. (Note: If the participant is not of the age of majority, parents will be contacted if the camper has an illness or accident that is of concern to the Health Caregiver and Camp Manager.

Parents will be contacted/consulted if a trip to Urgent Care, Emergency Room or other medical attention is necessary. If the parents/guardians of a minor cannot be reached, an Ohio Conference UCC designee will try to reach the Emergency Contact Person listed in this registration. I understand the information on this form will be shared on a "need to know" basis with camp staff. The camp has permission to obtain a copy of the camper's health record from providers who treat the camper, and these providers may talk with the program's staff about the camper's health status.

*** If for religious reasons you cannot sign this, contact the Ohio Conference UCC for a legal waiver which must be signed for attendance.

A COPY OF THE FRONT AND BACK SIDE OF YOUR INSURANCE CARD(S) MUST BE ATTACHED TO THIS FORM.

Checking this box confirms that you have read the medical waiver, that you understand it, and that you agree to be bound by it.

Signature _____ Date Signed _____

PLEASE RETURN THIS COMPLETED FORM TO: OUTDOOR MINISTRIES, 6161 BUSCH BLVD., SUITE 100, COLUMBUS OH 43229, **AT LEAST 3 WEEKS BEFORE YOUR CAMP BEGINS.** You may also scan and email to campregistrar@ocucc.org or fax to 614-885-8824.