Health Form
Ohio Conference UCC
Faith Formation and Outdoor Ministries

To ensure the health and safety of adult and youth participants in Ohio Conference UCC programs, we ask that you provide health information, including health insurance information below. If you are participating in an international program, you will be required to carry personal traveler's health insurance in addition to your regular health insurance policy when you are traveling abroad. Please disclose all health history and information as completely and thoroughly as possible.

Participant Information

Name _____
(First, Middle, Last)
Are the participant named above a a: ( ) Minor or ( ) Adult
Address _____
(Street, City, State, Zip)
Birth Date _____
Age at time of program _____
Gender _____
Email _____

Insurance Information

Is the participant covered by family medical/hospital insurance? ( ) Yes ( ) No
If yes, indicate Insurance Company _____
Policy Number _____
If you are traveling internationally, list information for your personal health travelers insurance.
Insurance Company _____
Policy Number _____
Family Physician Name _____
Phone _____
Family dentist/orthodontist Name _____
Phone _____
Name and phone of medical specialist(s)
_____
_____
_____

A copy of the front and back side of the insurance card(s) MUST be attached.

Emergency Contact Information

First Emergency Contact in case of illness or injury
(For minor, Custodial parent/guardian with legal custody):

Name _____
Address _____
Home Address (if different from above) _____
Relationship to Participant _____
Preferred Phone(s) _____
Email _____

Second Emergency Contact (For minor, custodial parent/guardian with legal custody):

Name _____
Address _____
Home Address (if different from above) _____
Relationship to Participant _____
Preferred Phone(s) _____
Email _____

For minor only, emergency contact if parents/guardians are not available:

Name _____
Address _____
Home Address (if different from above) _____
Relationship to Participant _____
PreferredPhone(s) _____
Email _____

Health History

The following must be filled in by the adult program participant or a minor's parent or guardian. The intent of gathering this information is to provide healthcare personnel and program leaders the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided upon arrival at the program or event. Provide complete information so that the program leaders can be aware of any and all needs you may have. This information is kept confidential from other program participants and will not be used to stigmatize the participant.

List any physical, mental or psychological conditions that the participant may have (Including such conditions as Epilepsy, Diabetes, ADHD, Depression, etc.)

Does the participant have:

( ) Sleep walking concern ( ) Bedwetting concern

Additional explanation of above if necessary:

Can the program participant swim? ( ) Yes ( ) No

Allergies

Please list all allergies including:
Food(s) _____
Medication(s) _____
The environment (insect stings, hay fever, etc.) _____

Please give detailed descriptions of allergies and reactions seen:

If participant has asthma, was an inhaler sent? ( ) Yes ( ) No
If there is a severe allergic reaction, was an Epi-Pen sent? ( ) Yes ( ) No

Restrictions

I feel the participant can without restrictions ( ) Yes ( ) No

If no, the participant needs the following restrictions or adaptations:

Medications

Does the participant take regular medications (either prescription or over-the-counter)

( ) Yes ( ) No

If yes, please list ALL medications (including over-the counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time while participating in the program. Keep medications in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

For each medication, please list: (attach additional sheet if necessary)

Name of Medication _____
Date started _____
Reason for taking _____
Time(s) of day it is given _____
Amount/dose given _____
How it is given _____

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Identify any medications normally taken by the participant that s/he will NOT be taking during the program:

Immunizations

Does the participant have current immunizations: ( ) Yes ( ) No
Does the participant have a current Tetanus booster: ( ) Yes ( ) No Date _____

Permissions

(For Minors) I attest that my minor child has received all required immunizations needed by school, and they are all up to date. If they are not, I understand and accept the risks to my child from not being fully immunized.

Sign Here

Parent/Guardian:_____

Sign Here

Over the Counter Medications (Minors/Camp Only)

The following non-prescription medications are stocked at our camp site by the camp and are used on an as-needed basis to manage illness and injury. Cross out those that the camper should NOT be given.

Acetaminophen (Tylenol)
Antihistamine/allergy medicine (Benadryl and Claritin) Calamine lotion
Hydrocortisone cream
Triple antibiotic ointment
Ibuprofen (Advil, Motrin)
Generic cough drops / Throat Spray Laxative (Ex-Lax)
Calcium carbonate (Tums)

I (parent) hereby give permission for Ohio Conference UCC Outdoor Ministries/Faith Formation Program to administer the following 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.

Sign Here

Signed_____ Date _____

Sign Here

Authorization for Treatment (Signed by All)

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 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 in the event that a trip to Urgent Care, Emergency Room or other medical attention is necessary. In the event that the parents of a minor cannot be reached, an Ohio Conference UCC designee will try to reach an Emergency Contact Person listed above.) I understand the information on this form will be shared on a “need to know” basis with camp staff. In addition 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.

Sign Here

_____

Signature of parent/guardian or adult camper/staff

Sign Here

***** 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 the insurance card(s) MUST be attached.

Additional Medication Information Sheet

Name of Medication ______________________________
Date started ______________________________
Reason for taking ______________________________
Time(s) of day it is given ______________________________
Amount/dose given ______________________________
How it is given ______________________________

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