

# Camp Bethel Adult Participant Health History Form 2010

Please PRINT. Complete and return to: **Camp Bethel, 328 Bethel Road, Fincastle VA 24090-4276.**

Information from this form will be held confidential by the camp staff and instructors. The intent of this form is to provide the leaders with information needed to provide appropriate emergency care. Keep a copy of this completed form for your records. Attach additional pages or descriptions as needed. Please PRINT.

Participant name: \_\_\_\_\_ Gender: M / F Birth date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
last name, first name m.i. month day year

Home phone: (\_\_\_\_) \_\_\_\_\_ Work phone: (\_\_\_\_) \_\_\_\_\_ Spouse's cell: (\_\_\_\_) \_\_\_\_\_

Name of who to call in case of emergency: \_\_\_\_\_ their cell/home phone: \_\_\_\_\_

**INSURANCE INFORMATION:** (Camp Bethel provides only limited secondary medical insurance for participants.)  
**Required: You must attach a photocopy or scan of the front & back of your medical insurance card and return it with this form.**  
 Is each participant covered by family medical / hospital insurance? \_\_\_Yes. \_\_\_No. Is the camper covered by Medicaid? \_\_\_Yes. \_\_\_No.  
 Participant's Primary Care Physician: \_\_\_\_\_; Phone: (\_\_\_\_) \_\_\_\_\_;

**ALLERGIES:** List all known allergies, describe your reaction and the best management of the reaction; use extra paper if needed.  
 Medication allergies: \_\_\_\_\_  
 Food allergies: \_\_\_\_\_  
 Other allergies: \_\_\_\_\_

**MEDICATION(S) BEING TAKEN:**  
 Please list ALL medications (including non-prescription drugs) that you will bring during your course time. Keep it in the **original packaging** naming prescribing physician, name of medication, dosage, and frequency of administration.  
 \_\_\_ I take NO medications on a routine basis.  
 \_\_\_ During the event, I will bring the following medication(s) for myself: (Attach additional pages for more information.)

<u>MEDICATION</u>	<u>DOSAGE &amp; TIMES TAKEN EACH DAY</u>	<u>REASON FOR TAKING</u>

**PERMISSION TO ADMINISTER OVER-THE-COUNTER MEDICATIONS:**  
 In case of headaches, low grade fever, slight upset stomach, mild diarrhea, mild allergic reactions or cold symptoms, the camp leaders have my permission to administer the following to me: (Check the box to the left of each medication allowed for you/your camper.)

<input type="checkbox"/> Tylenol (or comparable generic)	<input type="checkbox"/> Tums Antacid (or generic)	<input type="checkbox"/> Sudafed (or generic)	<input type="checkbox"/> Benadryl (or generic)	Others: _____
<input type="checkbox"/> Ibuprofen (or generic)	<input type="checkbox"/> Imodium AD (or generic)	<input type="checkbox"/> Cold/Cough Medicine	<input type="checkbox"/> Pepto Bismol (or generic)	

**IMMUNIZATION HISTORY:** If you have been immunized, indicate details below. **Immunizations are NOT required for participation.**  
 Due to the nature of activities, tetanus immunization within last 5 years is preferred. Choosing one from the list below, please give date of most recent DTP (diphtheria/tetanus/pertussis), date: \_\_\_\_\_  
 TD (tetanus/diphtheria), date: \_\_\_\_\_  
 Tetanus, date: \_\_\_\_\_  
 \*This information may be helpful in case of emergency.  
 Please provide the following information, if known, giving date of last injection/ingestion.  
 Have you had the following series? (circle and date if yes)  
 Varicella (Chicken Pox): yes / no date: \_\_\_\_\_ Hepatitis B: yes / no date: \_\_\_\_\_  
 Oral Polio (OPV) or Injectable Polio (IPV): yes / no date: \_\_\_\_\_  
 Haemophilus Influenza B (HiB): yes / no date: \_\_\_\_\_  
 MMR: yes / no date: \_\_\_\_\_ OR each, separately below:  
 Measles: yes /no date: \_\_\_\_\_, Mumps: yes /no date: \_\_\_\_\_, Rubella: yes /no date: \_\_\_\_\_

**MEDICAL HISTORY:** Describe any injury, illness, disease, treatment, surgery, or affliction the camp leaders should know in case of emergency: \_\_\_\_\_

**ADDITIONAL INFORMATION:** Describe other physical, emotional, or behavioral concerns: \_\_\_\_\_

**The following 2 boxes must be complete for attendance\*.**  
 \*If for religious reasons you cannot sign either box, contact the camp for legal waivers that must be signed for participation.

**Physical Assessment of Participant: To be signed by adult participant or medical personnel.** We encourage participants to consult your family's primary care physician to assess your current health and physical abilities. Provide any updates or changes to this information to leaders at check-in.  
 I am physically able to participate in activities or instruction as described in the course information (unless specified in restrictions provided on additional paper).  
**Signature of participant or medical personnel:** \_\_\_\_\_; Date: \_\_\_\_\_  
**Printed name of person signing this box:** \_\_\_\_\_; Phone: \_\_\_\_\_

**Participant Authorizations:**  
 I have read and understand the course information. I understand that I will be participating in physical activities (including, but not limited to those listed in the course descriptions) and the potential for accidents exists. I understand that the camp/instructors have established guidelines to minimize risks to provide a safe environment and that Camp Bethel programs are accredited by the American Camp Association in accordance to adherence to over 300 quality standards. In consideration of acceptance into this course, I indemnify and hold harmless Camp Bethel, the Virginia District Board-Church of the Brethren, Inc. and its staff, volunteers and officers from any and all liability, claims, damage, injury or illness sustained by me, and I verify that the information on this Health History Form is correct and complete as far as I know. This form may be copied for camp records, and I hereby give permission to the camp to provide routine health care, administer prescribed medications as listed above, administer over-the-counter medications as listed above, and seek emergency medical treatment. I agree to the release of any records necessary for emergency purposes. I give permission to the camp to arrange necessary emergency medical transportation for me. In the event I cannot communicate in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment for me including ordering x-rays, administering tests, and admittance to a hospital, and I understand that Camp Bethel provides only limited secondary medical insurance coverage for participants. I have attached proof of primary personal/family medical insurance coverage for me as required for camp attendance, and I agree to read all information included in confirmation materials sent to me after registration and to share this information with my emergency contact person, and to read, sign and return any and all applicable forms and waivers, and I permit photos, video and audio of activities or interviews that may include me to be used in camp/course promotion without liability or remuneration.

**Signature of participant:** \_\_\_\_\_ Date: \_\_\_\_\_  
**Printed name:** \_\_\_\_\_ Phone number: (\_\_\_\_) \_\_\_\_\_