

Camp Bethel 2024 Camper Health & Information Form v. 04.20.2023 Complete this online at CampBethelVirginia.org/health

A parent or legal guardian must complete and submit this form at least 7 days prior to your camp dates or as soon as possible. Keep a copy of this completed form for your records. The intent of this form is to provide information needed in case of emergency care. The directors keep information from this form confidential. Submit additional descriptions or updates if needed via CampBethelOffice@gmail.com, attention: Health Coordinator. Provide any urgent health updates at check-in on the first day of camp. Insurance is not required for camp attendance, and Camp Bethel provides only limited secondary accident insurance for participants. If you have insurance and you have plans to be away or unreachable during your child's camp time, you must e-mail a scan or image of the front & back of your family/child medical insurance card to CampBethelOffice@gmail.com, or upload the scan/image at www.CampBethelVirginia.org/health. In any emergency, illness, or injury, we will immediately contact the parent/guardian or the emergency contact. **All answers on this form are REQUIRED.**

Camper's FIRST name _____ Camper's LAST name _____

Camper's Date of Birth _____ Camper's Gender _____

Check the dates that most closely match WHEN your child will attend camp.

June 9-14 (Week 1) June 23-28 (Week 3) July 7-12 (Week 5) July 21-26 (Week 7)
 June 16-21 (Week 2) June 30-July 5 (Week 4) July 14-19 (Week 6)

First & Last Name of custodial Parent/Guardian who is the primary contact for this camper _____
This is the parent/guardian(s) with whom the camper has primary residence and who is our primary contact.

City and State of residence _____

Main phone of custodial Parent/Guardian _____ *include area code, (ex: 540-555-1234)*

Other phone of custodial Parent/Guardian _____ *include area code, (ex: 540-555-4321)*

Emergency Contact Information: *If we need to give important information to parent/guardian.*

Who to call if parent/guardian is not available? _____ Relation to camper _____

Their main phone _____ *include area code, (ex: 540-555-5678)*

Their other phone _____ *include area code, (ex: 540-555-8765)*

Who will pick up your child? List the first and last names of any adults you authorize to drive your camper home from camp.

ALLERGIES & RESTRICTIONS: List all known allergies and restrictions. Describe the severity of each including your child's reaction and the best management of the reaction. Describe the best accommodation, adaptations, or limitations of any restrictions. Attach additional paper if needed or send to CampBethelOffice@gmail.com. If none, leave blank or write NONE.

Food allergies: _____

Medication allergies: _____

Other or environmental allergies: _____

Restrictions or exemptions to camp activities: _____

Other restrictions or health concerns: _____

MEDICAL HISTORY: Describe any injury, illness, medical treatment, or surgery the camp should know in case of emergency.

ADDITIONAL INFORMATION: Describe other physical, emotional, or behavioral concerns, or any conditions requiring medication, treatment, or special restrictions or considerations while at camp.

PERMISSION TO ADMINISTER OVER-THE-COUNTER MEDICATIONS: In case of headaches, low grade fever, slight upset stomach, mild diarrhea, mild allergic reactions, aches and pains, or cold symptoms, the Camp Bethel Health Coordinator has my permission to administer the following to over-the-counter medications (or their generic) to my child: Benadryl, Cold/Cough Medicine, Ibuprofen, Imodium AD, Pepto Bismol, Sudafed, Tums Antacid, and Tylenol for Children.

YES to all. Yes, but with these exceptions: _____ NO.

MEDICATION NECESSARY DURING CAMP: If camper will require medication during camp (prescribed, over-the-counter, as needed), you must indicate YES* below AND complete the "Camp Bethel Medications Instructions" form on the next page.

This camper will NOT take medication during camp.

YES* this camper requires medication, and I will complete the **Medication Instructions form** on the next page.

IMMUNIZATION HISTORY -OR- WAIVER: If you voluntarily exempt this child from school-required immunizations, you must sign the waiver (#3) below if you do not check YES in #1 or do not provide tetanus date in #2. (*Immunizations are NOT required for attendance.*)

1. Are all immunizations required for public school attendance up to date for this camper? If you choose not to answer, you must sign the waiver in #3 below. YES*, or No, or I choose not to answer. (Not required for attendance.)
2. Month and Year of last tetanus shot. If you choose not to answer, you must sign the waiver in #3 below.
 . YES, _____ (MM/YYYY), or I choose to sign the waiver in #3 below

Immune Waiver: If you did NOT check YES in #1 above or did NOT provide tetanus date in #2 above, please sign* and date** the following statement: ***"I understand and accept the potential risks to one who is not fully immunized."***

Parent/Guardian signature* _____, Date signed** _____
* * * * *

GETTING TO KNOW YOUR CAMPER: The following questions will help us ensure a quality camp experience for your camper. Get your camper's opinion, remembering that our program focus is relational small-group community living, and your camper will spend all day each day with her/his group. Attach additional pages of helpful information.

- Check all that apply:** Returning Camp Bethel Camper. *How many summers total, not including 2022?* _____
- 1st time at this camp. 1st overnight away from home. Have attended other camp before.
- Can swim in deep water. Non-swimmer. No bike experience. Experienced bike rider.

Camper's personality when living, playing, & working with others: _____

Camper's interests, hobbies, likes: _____

As your camper thinks about camp, what excites her/him? _____

What concerns her/him? _____

What outcomes from this experience do you hope for your camper? _____

How did you learn about Camp Bethel and/or get this form? _____

I/We chose Camp Bethel because... _____

Church membership, if any (not required for attendance) _____

PARENT/GUARDIAN VERIFICATION OF CAMPER HEALTH & INFORMATION FORM:

The following box must be signed by parent/guardian for camper attendance:

"I verify that the information on this Camper Health & Information Form is complete as far as I know. This form may be copied for camp records. I will provide updates (if any) to this information at check-in on the first day of camp."

Parent/Guardian signature _____, Date signed _____

CAMP BETHEL MEDICATION INSTRUCTIONS (Complete ONLY if your camper takes medication during camp.)

If you will be sending any medication for your camper to take during her/his time at camp, YOU MUST RECORD precise time and dosage instructions below and return this form to Camp Bethel. All camper medications must be checked in to our Medical Staff or Health Coordinator during check-in on the first camp day. All medications are stored and dispensed by the Health Coordinator unless special arrangements are made through the Health Coordinator and Camp Director. Only send enough medication for the camper's time at camp. Medications MUST be in the original, labeled packaging and container naming prescribing physician, camper name, medication name, dosage, and frequency instructions.

Camper's FIRST name _____ Camper's LAST name _____

LIST ALL MEDICATIONS TO BE ADMINISTERED to this camper that you will be transferring to our Health Coordinator at check-in. List names of medications (including non-prescription) and the reasons for taking.

SCHEDULE OF DOSAGES: In the chart below, list the name of each specific medication. Under each medication, list the dose to give beside each day and specific time we should administer it to your camper. See the "Example Column." The Health Coordinator will initial the box for each specific time the dosage has been dispensed. The times listed in the chart correspond to meals: 8:00am breakfast, 12:30pm lunch, 5:30pm dinner; and bedtime 9:30pm.

		Medication #1		Medication #2		Medication #3		Medication #4		"Example Column"	
		Dose to give each time	Health Coord initials	Dose to give each time	Health Coord initials	Dose to give each time	Health Coord initials	Dose to give each time	Health Coord initials	Dose to give each time	Health Coord initials
Write medication names here ==>		Penicillin: 1 tablet twice daily at breakfast and bedtime									
Sunday	5:30 pm										
	9:30 pm									1 tablet	
Monday	8:00 am									1 tablet	
	12:30 pm										
	5:30 pm										
	9:30 pm									1 tablet	
Tuesday	8:00 am									1 tablet	
	12:30 pm										
	5:30 pm										
	9:30 pm									1 tablet	
Wednesday	8:00 am									1 tablet	
	12:30 pm										
	5:30 pm										
	9:30 pm									1 tablet	
Thursday	8:00 am									1 tablet	
	12:30 pm										
	5:30 pm										
	9:30 pm									1 tablet	
Friday	8:00 am									1 tablet	
	12:30 pm										
	5:30 pm										

MEDICATION AS NEEDED: List meds you are checking into the Health Coordinator in case they are needed AND a description of the condition for which you feel they should be administered plus the dosage.
