Camp Bethel Staff/Volunteer Minor (under age 18) Health Form 2021 revised 05.14.2021

A parent or legal guardian must complete and sign this form *(grey signature *box* at bottom of form). Information from this form will be held confidential by the Health Coordinator and Camp Directors. The intent of this form is to provide the Directors 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. Provide changes to this form to the Health Coordinator as needed. Please PRINT.* ***Please attach a copy/scan of your family medical insurance card, if any.***

FIRST name _____ LAST name _____ Birth Date_____

Permanent address (where we will mail your W2s) _____

City_____ State_____ Zip_____

Staff cell phone_____ Staff home phone_____

Staff email address_____

Parent/Guardian's: *First & Last Name*_____

Their main phone _____ *include area code, (ex: 540-555-1234)*

Emergency Contact Information: *First & Last Name*_____

Their main phone _____ *include area code, (ex: 540-555-1234)*

Other contact in emergency_____

Their main phone _____ *include area code, (ex: 540-555-1234)*

INSURANCE INFORMATION: If you have insurance, attach a photocopy or scan of the front & back of your medical insurance card and return it with this form. Contact our office for exceptions.

Are you covered by family medical/hospital insurance? ____Yes. ____No. Are you covered by Medicaid? ____Yes. ____No.

Primary Care Physician: _____; Phone: (____)_____;

Hospital affiliation: _____

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 _____

Dietary restrictions_____

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 over-the-counter medications (or their generic): Benadryl, Cold/Cough Medicine, Ibuprofen, Imodium AD, Pepto Bismol, Sudafed, Tums Antacid, and Tylenol.

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

MEDICATION NECESSARY DURING CAMP EMPLOYMENT: List ALL medications (including non-prescription drugs) on the Medication Form. Bring enough medication to last the entire time at camp. Keep it in the original packaging naming prescribing physician, name of medication, dosage, and frequency of administration. If, during your employment at Camp Bethel, you will be taking medication that might impair your ability to perform essential functions described in your position description, call today to speak with the Camp Director or Health Coordinator.

___ I take NO medications on a routine basis.

___ YES, I take routine medication, and I will complete the Medication Instructions form on the next page.

IMMUNIZATION HISTORY *-OR-* WAIVER: Families who voluntarily exempt their children from school-required immunizations OR who voluntarily exempt themselves from providing proof of immunization must sign the waiver (#3) below if you do not check YES in #1 or provide tetanus date in #2.

1. Are all immunizations required for school attendance up to date for this camper? If you choose not to answer, you must sign the waiver in #3 below. ___ YES, or ___ I choose to sign the waiver in #3 below.
2. Month and Year of last tetanus shot. If you choose not to answer, you must sign the waiver in #3 below. _____/_____ (MM/YYYY), or ___ I choose to sign the waiver in #3 below.
3. **Immunization 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."***

VACCINATION STATUS: _____ Fully Vaccinated*, _____ Partially Vaccinated*, _____ Not Vaccinated

*If fully or partially vaccinated, you will be asked to submit proof-of-vaccination (a photo of your vaccination card) to our Camp Bethel email address: CampBethelOffice@gmail.com

The following box must be signed. If for religious reasons you cannot sign, contact the camp for legal waivers that must be signed for camp attendance. If you have insurance, attach a photocopy or scan of the front and back of your medical insurance card and return it with this form.

Parent/Guardian Authorizations: I hereby request that my child be accepted to attend Camp Bethel. I have read and understand the 2020 Summer Staff Information packet, the Record of Agreement packet, and the summer camp brochure, including staff policies, the camp rules and behavior policies, position descriptions, the program descriptions and the activities listed for my child's service at camp. I understand that my child will be participating in many physical activities (including, but not limited to those listed in the program descriptions) and the potential for accidents exists. I understand that the camp has established guidelines to minimize risks to provide a safe environment and that Camp Bethel is licensed by Virginia to operate a Summer Camp, Dining Hall and Swimming Pool, and that Camp Bethel is accredited by the American Camp Association and adheres to over 300 quality standards. In consideration of acceptance to Camp Bethel,

I indemnify and hold harmless Camp Bethel, the Virlina District Board–Church of the Brethren, Inc. and its staff/officers from all liability, claims, damage, injury or illness sustained by my child, and

I hereby give permission to the camp to provide routine health care, administer prescribed medications and over-the-counter medications as listed above, and seek emergency medical treatment. This form may be copied for camp records. I agree to the release of any records necessary for emergency purposes. I give permission to the camp to arrange emergency medical transportation for my child. In the event I cannot be reached, I hereby give permission to the physician selected by the camp to secure and administer treatment for my child including ordering x-rays, administering tests, and admittance to a hospital, and

I understand that Camp Bethel provides Workers Insurance and limited secondary medical insurance coverage for participants. I will attach proof of primary personal/family medical insurance coverage for my child, if any, as requested for camp attendance on the Health Form received in my confirmation packet after registering, and

I understand the active nature of the camp activities and give permission for my child to participate fully and to engage in all camp activities including the group challenge & initiatives course, climbing wall, high ropes course, and archery, unless otherwise noted under restrictions on the front of this application. I understand that climbing at any height, using climbing equipment (climbing wall/high ropes course) and archery activities may have inherent risks and that participation may involve accidents that could result in injury. I understand that climbing wall, high ropes and archery activities are "challenge by choice" and that my child will not be forced to participate, and

I understand that my child's service at Camp Bethel includes transportation ON SITE, and I permit my child to be transported on site in camp-approved vehicles driven by camp-approved drivers, and

I understand that my child's service at Camp Bethel likely includes transportation OFF SITE (adventures, trips, service projects), and permit my child to leave Camp Bethel accompanied by authorized camp personnel for approved out-of-camp activities at camp-approved locations, to be transported in camp-approved vehicles driven by camp-approved drivers, and, if applicable while off site, for camp personnel as authorized by the Director in consultation with the Health Coordinator to administer prescribed medications and over-the-counter medications to my child as listed above, and

I agree to read all information included in continuing communications, letters and e-mails and to discuss this information with my child, and to read, sign and return any and all applicable forms , and

Should it become necessary for my child to leave site or return home because of illness, homesickness or other reason, I will accept the Director's decision and arrange for transportation, and

I permit camp photos, video and audio of activities or interviews that may include my child to be used in camp promotion without liability or remuneration, and

I verify that the information on this form is correct as far as I know, and I verify the Physical Assessment of this child as described below.

Physical Assessment of participant by parent, legal guardian or medical personnel: *We encourage parents/guardians to consult your child's primary care physician to assess your child's current health and physical abilities. Provide any updates or changes to this information to the Health Coordinator at the Camp Bethel office.*

This child is physically able to participate in all camp/staff activities listed above and in the Summer Camps Brochure and Staff Information (unless otherwise noted under restrictions above), and I will provide an update to this child's health status and Health Form, if any.

***Signature of parent or legal guardian:** _____ *Date: _____

***Printed name of who signed this form:**_____ ***Phone number:**_____

CAMP BETHEL MEDICATION INSTRUCTIONS (*Complete ONLY if you will take medication during camp.*)

If you will be sending any medication for your minor staff member to take during her/his employment at camp, YOU MUST RECORD precise time and dosage instructions below and return this form to Camp Bethel. All medications must be verified by our Health Coordinator. All medications are stored in NON-camper staff quarters unless special arrangements are made through the Health Coordinator and Camp Director. Medications MUST be in the original, labeled container with your name. medication name & strength, and dosage instructions. Only bring enough medication for your time at camp.

Staff's FIRST name _____ Staff's LAST name _____

LIST ALL MEDICATIONS TO BE ADMINISTERED to this minor staff member that you will be transferring to our Health Coordinator. 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 administered. *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"***	
Write medication names here ==>										***Penicillin:*** *1 tablet twice daily at breakfast and bedtime*	
		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
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.

_____

_____