

CHAMBERS WESLEYAN CAMP – HEALTH FORM 2021

*To be filled out by **all** campers*

Name: _____ Sex: M / F Birth Date: _____ Age: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Health Ins. Co. _____ Member/ID No. _____ Group No. _____
 Parent/Guardian: _____ HomePhone: _____ CellPhone _____
 Emergency Contact (Not listed above): _____ Telephone: _____

Vaccinations: Please attach a copy of your child’s most recent vaccination list WITH dates. OR: If your child is not vaccinated, please attach a copy of your school exemption letter.

Vaccination List attached _____ Exemption letter attached _____ (Please check one)

Medications: Please fill out the attached form for all of your child’s prescribed medications. *All campers Must fill out form*

*Medication List attached _____

Allergies: Is your child allergic to any Medications? No: _____ Yes: (please list) _____

Is your child allergic to any Food? No: _____ Yes: (please list) _____

Does your child have any Other allergies? No: _____ Yes: (please list) _____

Other: 1. Has your child been exposed to any communicable diseases recently?

No: _____ Yes: (please explain) _____

2. Does the camper have any limitations or restrictions that would prevent them from participating in any physical activities?

No: _____ Yes: (please explain) _____

3. Does this camper struggle with: Bedwetting: No: _____ Yes: _____

Sleepwalking: No: _____ Yes: _____

Night Terrors: No: _____ Yes: _____

4. Are there any other Medical or Additional information our staff should be aware of concerning this camper? (ex: Dietary, Disability, Major operations, Special precautions, Seizures, Emotional concerns, ect.)

No: _____ Yes: (please explain) _____

I hereby grant permission for my child/self to attend/work at Chambers Wesleyan Camp. In the event of an emergency, I hereby give my permission for self/him/her to receive any such medical treatment as is necessary for serious illness or injury, as administered by the camp health staff, and/or hospital.

Signature of Parent/Legal Guardian, or Self if over 18

Date

*A health form without a signature will not be accepted.

<u>*FOR CHECK IN STAFF ONLY*</u>	Yes:	No:	
Vaccination form	_____	_____	
Medication form	_____	_____	*Medications checked and signed in with nurse*
Physical Exam Complete	_____	_____	
Observations	_____		
Head Lice Check Completed	_____	_____	
COVID-19 Documentation	_____	_____	Type: _____