2017 CAMPING & YOUTH MINISTRIES

Presbytery of Des Moines

HEALTH STATEMENT

Please complete the entire form (both sides) for each camper – make as many copies as necessary. This form is to be filled out and signed by parent / guardian and brought to camp. If last physical examination has been more than 12 months prior to the opening of camp, this statement is to be completed and signed by the physician.

Camper's Name _____ Birth Date _____ Gender ____

Camper's Cell Phone (if brought to camp) _____

Parent / Guardian _____

Address _____
(Street / RR) (City) (State) (Zip)

Phone-10 digits: (Home) _____ (Work) _____(Cell) _____

Emergency Contact _____

Address _____
(Street / RR) (City) (State) (Zip)

Phone-10 digits: (Home) _____ (Work) _____(Cell) _____

Date of last physical examination _____(mm/yyyy)

Health History (please give dates if applicable): (mm/yyyy)

Ear Infections	_____	Diabetes	_____
Rheumatic Fever	_____	Asthma	_____
Seizures	_____	Measles	_____
Chicken Pox	_____	Mumps	_____

<u>List Specific Allergies</u>:

Food Allergies _____

Insect and/or Animal Allergies _____

Medication Allergies _____

Recent illness or surgery (type and date): _____

_____

Immunization Record: (Please give dates: mm/yyyy)

D P T _____	Hepatitis B _____	Measles _____	T B Test _____
Polio _____	Tetanus _____	Booster _____	Other _____

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PERMISSION FORM

Please complete the entire form (both sides) for each camper – make as many copies as necessary.

My child (camper)/I (adult) _____ has/have permission to attend

camp and to participate in usual camp activities: Yes _____ No_____

Swimming: Yes _____ No _____

I understand that first aid will be available; that the campers will be closely supervised; and that if a serious illness or injury develops, medical and / or hospital care will be given. However, the staff is not responsible in case of accidental injury or illness. I hereby give permission to the physician selected by the person in authority at the camp to order x-rays, routine tests and treatment for the health of my child, and in the event that I can not be reached in an emergency, I hereby give permission to the physician selected to secure proper treatment for, and to order injection and / or anesthesia and / or surgery for my child as named above.

Signature of Parent / Guardian _____ Date _____

Address _____
(Street / RR) (City) (State) (Zip)

Phone-10 digits: (Home) _____(Work)_____(Cell)_____

Insurance Carrier: _____

Policy Holder: _____

Policy Number: _____

* * * * * * * * * * * * *

Physician's signature (if needed) _____Date _____

Address _____
(Street / RR) (City) (State) (Zip)

Phone-10 digits: _____

Included in the camp fee is a group insurance policy covering non-chronic illness or accidental injury during the event, and en-route to and from. This coverage is excess coverage to insurance maintained by parents. In the event you receive treatment at camp, the bill will be directed through your primary insurance.