

# Heartland SEP 2008

## Medical History and Release Form



OFFICE USE ONLY

Date Rec'd \_\_\_\_\_

- Camper  
 Minicamper  
 Volunteer Staff

Health Staff Notes:

**FILL OUT COMPLETELY - ONE FOR EACH CAMPER/STAFF/MINICAMPER**

Heartland SEP requires that this form be completed and signed by the participant and/or parent/guardian (if a minor) before he or she may participate in *any* activities at Heartland SEP. All information will be kept confidential and will only be shared with camp directors, nurse, and other persons when deemed necessary.

### Participant Information

Name: \_\_\_\_\_ (Circle): Male / Female  
First Name Middle Initial Last Name

Home address: \_\_\_\_\_  
Street Address City State/Province Zip/Postal Code

Home phone:(\_\_\_\_\_) \_\_\_\_\_ Work or additional phone:(\_\_\_\_\_) \_\_\_\_\_

Social security no: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age at camp: \_\_\_\_\_

Parent(s)/guardian(s) names (If participant is under 18): \_\_\_\_\_

Parent/guardian home phone & work phone if different than above: Home:(\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_

### Emergency Contacts List two contacts (not parents/guardians).

If a parent/guardian cannot be reached during the event the following two individuals may be contacted in the event of an emergency and have permission to make medical care or emergency decisions:

\_\_\_\_\_  
Full Name Relationship Evening Phone Number Day Phone Number

\_\_\_\_\_  
Full Name Relationship Evening Phone Number Day Phone Number

### Insurance Information (Please attach a copy of insurance card or form.)

Participant is covered by medical insurance: **YES / NO**

If YES, name of policyholder: \_\_\_\_\_

Name of insurance company: \_\_\_\_\_ Policy no.: \_\_\_\_\_ Group no.: \_\_\_\_\_

### Medications Being Taken

- Bring enough medication to last the entire time at camp.
- Keep all medications in the original packaging/bottle that identifies the prescribing physician, the name of the medication, the dosage, etc.
- Please list ALL medications, including over-the-counter or nonprescription drugs, taken routinely.
- No medications should be brought to camp except prescription or allergy medications (i.e., no aspirin, Tylenol, etc.).
- All medications, including vitamins, must be turned in and dispensed by health care personnel.

Will the participant take medications at camp? (Circle): **YES / NO**

If **YES**, please list and describe medications below.

Name of Medication	Dosage	Specific times taken each day	Reason for taking
Med #1			
Med #2			
Med #3			
Med #4			
Med #5			

(turn page over)

**General Health Questions** Check all that pertain to the participant and provide information about supportive health care. This information is used to educate counseling staff about participant needs and provide camp healthcare personnel the background to provide appropriate care. Please be as thorough as possible.

- Participant has **NO** chronic health concerns and is capable of full participation in this program.
- Participant has the following chronic health concern(s):
- |  |   |  |  |  |
|--|---|--|--|--|
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Diabetes                       | <input type="checkbox"/> Headaches     | <input type="checkbox"/> Menstrual cramps  | <input type="checkbox"/> Sleepwalking            |
| <input type="checkbox"/> Bedwetting        | <input type="checkbox"/> Frequent ear infections        | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Seizures/epilepsy | <input type="checkbox"/> Skeletal disease/injury |
| <input type="checkbox"/> Behavior disorder | <input type="checkbox"/> Other (please describe below): |  |  |  |

**Provide information about supportive health care needed for each checked item:**

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**Allergies** List all known allergies with specifics.

- NONE**
- Insect stings \_\_\_\_\_
- Foods \_\_\_\_\_
- Medications \_\_\_\_\_
- Other \_\_\_\_\_

**Special Considerations** (Note: It is the responsibility of the participant to manage dietary restrictions and activity limitations and/or adaptations.)

- Dietary restrictions     Activity limitations

**Provide information about each checked item:**

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**Additional Health Information** Provide any additional information about the participants' behavior and physical, emotional, or mental health about which the camp should be informed.

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## Signature and Release

Please **initial** by each item below and **sign**:

**PERMISSION TO SECURE EMERGENCY SERVICES:** I am giving my consent in advance for medical treatment at an appropriate medical facility in case of illness or injury. I will be responsible for the costs of such services if not covered by my insurance. Initials \_\_\_\_\_

**RELEASE OF LIABILITY REGARDING SPECIAL HEALTH CONDITIONS:** I agree to hold harmless and indemnify Heartland SEP, the Worldwide Church of God, their staff, agents, and employees from any and all liability, loss, damages, costs, or expenses which are sustained, incurred or required arising out of the actions of the participant in the course of the camp/event. Initials \_\_\_\_\_

I am stating that I am aware of and accept the risk inherent in the program activity. Initials \_\_\_\_\_

I attest that all information on both sides of this form is correct. Initials \_\_\_\_\_

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature (for participants under 18): \_\_\_\_\_ Date: \_\_\_\_\_

Please mail this completed form to:  
**Linda Holmes, Box 46, Woodhull, IL 61490**  
**no later than July 11, 2008**

Should any significant changes in health status occur between the time this form is completed and when the participant arrives at camp, please communicate these changes in writing.