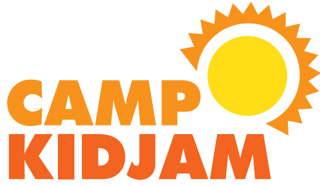


2013 Camp KidJam Health Form

IMPORTANT!

- **EVERY person attending Camp KidJam MUST fill out this form! This includes kids AND leaders. Please be sure to have ALL health forms upon arrival to check-in at the camp location. Our First Aid staff will count each form to make sure that we have one for every camper and/or leader.**

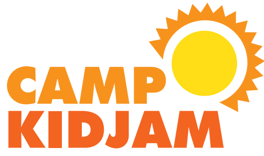
- **Although it is not mandatory, we recommend that every attendee, leader or child, has health insurance. If you have health insurance, please attach a copy of the attendee's insurance card to this form.**

- **Please fill out pages 1-3 of this form, leaving page 4 for Camp Kidjam to document any medical attention the attendee receives while at camp.**

- **The First Aid staff at Camp KidJam realizes the importance of all the information on these forms and will keep these forms in a safe and secure place.**

- **Please make TWO copies of this form for each person. One for Camp KidJam and one for the church staff to keep as they are traveling to and from camp.**

Still have questions? Please feel free to contact us at info@campkidjam.com.



Health Form

Dates attendee will be at camp: _______________ to _______________
Month/Day/Year Month/Day/Year

Name of attendee: ____
First Middle Last

❒ Male ❒ Female Birth date: _______________ Age on arrival at camp: _______

Home address:

____
Street address City State Zip

Parent/legal guardian/spouse to be contacted in case of illness or injury:

Name: ______________________ Relationship to attendee: ______________ Phone number: (____) ____-______

Home address:

____
(if different from above) Street address City State Zip

Second parent/legal guardian or other emergency contact:

Name: ______________________ Relationship to attendee: ______________ Phone number: (____) ____-______

Allergies: ❒ No known allergies. ❒ Attendee is allergic to: ❒ Food ❒ Medicine ❒ Environment (insect stings, pollen, etc.)
(If attendee has allergies, please describe below what the camper is allergic to and the reaction seen.)

Diet, Nutrition: ❒ This attendee eats a regular diet. ❒ This attendee eats a regular vegetarian diet.
❒ This attendee has special food needs. **(Please describe below.)**

Restrictions: ❒ I have reviewed the program and activities of the camp and feel the attendee can participate without restrictions.
❒ I have reviewed the program and activities of the camp and feel the attendee can participate with the following restrictions or adaptations. **(Please describe below.)**

Medical Insurance Information: Although it is not mandatory, we recommend that every attendee, leader or child, has health insurance. **Please attach a copy of your insurance card to this form. Copy both sides of card, if necessary.**

Insurance company: ______________________________ Policy number: ______________________________

Medication: ❒ This attendee will not take any daily medications while attending camp.
❒ This attendee will take the daily medications listed below while at camp.

"Medication" is any substance a person takes to maintain and/or improve health. This includes vitamins and natural remedies. **The attendee's medication must be in the original container with their name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.**

The following non-prescription medications may be stocked in the Camp KidJam First Aid Office and are used on an as-needed basis to manage illness and injury. **Cross out those the attendee should NOT be given.**

Acetaminophen (Tylenol)
Ibuprofen (Motrin, Advil)
Phenylephrine decongestant (Sudafed PE)
Pseudoephedrine decongestant (Sudafed)
Antihistamine/allergy medicine (Benadryl)
Guaifenesin cough syrup (Robitussin)
Generic cough drops
Calamine lotion
Antibiotic cream (Neosporin)
Aloe
Lidocaine topical (Solarcaine)
Calcium carbonate (TUMS)
Bismuth Subsalicylate (Pepto Bismol)
Anti-nausea medicine (Emetrol)
Anti-diarrheal medicine (Imodium AD)

Name: __________ First __________ Middle __________ Last __________ Church Name: ______________ Team Color ______________

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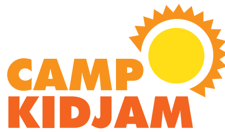

Health Form

Name: ____
First Middle Last

❒ Male ❒ Female Birth date: _______________

Immunization History: Provide the month and year for each immunization. Starred (★) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach it to this form. **Adults (18 years of age or older) do not need to complete this section of the form.** If any attendee has not been immunized, please sign the section below.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, tetanus, pertussis ★ (DTaP) or (TdaP)						
Tetanus booster ★ (dT) or (TdaP)						
Mumps, measles, rubella ★ (MMR)						
Polio ★ (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella ❒ Had chicken pox (chicken pox) Date:						
Meningococcal meningitis (MCV4)						
H1N1 vaccine (Swine flu)						

Tuberculosis Test (TB)	Date:	❒ Negative	❒ Positive

If the attendee has not been fully immunized, please sign the following statement: **I understand and accept the risks to the attendee from not being fully immunized.**

Signature of attendee: ______________________________ Date: ______________
(if over 18 years of age)

Signature of parent/legal guardian: ______________________________ Date: ______________

Relationship of attendee: ______________________________

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does the attendee:

1. Ever been hospitalized? ❒ Yes ❒ No
2. Ever had surgery? ❒ Yes ❒ No
3. Have recurrent/chronic illnesses? ❒ Yes ❒ No
4. Had a recent infectious disease? ❒ Yes ❒ No
5. Had a recent injury? ❒ Yes ❒ No
6. Had asthma/wheezing/shortness of breath? ❒ Yes ❒ No
7. Have diabetes? ❒ Yes ❒ No
8. Had seizures? ❒ Yes ❒ No
9. Had headaches? ❒ Yes ❒ No
10. Wear glasses/contacts/protective eyewear? ❒ Yes ❒ No
11. Had fainting or dizziness? ❒ Yes ❒ No
12. Passed out/had chest pain during exercise? ❒ Yes ❒ No
13. Had mononucleosis (mono) during the past 12 months? ❒ Yes ❒ No
14. If female, have problems with periods/menstruation? ❒ Yes ❒ No
15. Have problems with falling asleep/sleepwalking? ❒ Yes ❒ No
16. Ever had back/joint problems? ❒ Yes ❒ No
17. Have a history of bedwetting? ❒ Yes ❒ No
18. Have problems with diarrhea/constipation? ❒ Yes ❒ No
19. Have any skin problems? ❒ Yes ❒ No
20. Traveled outside of the country in the past nine months? ❒ Yes ❒ No

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside of the country, please name the countries visited and the dates of travel.

Health Form

CAMP KIDJAM

Name: ______________________________
First Middle Last

❒ Male ❒ Female Birth date: ______________
Month/Day/Year

Mental, Emotional and Social Health: Check "Yes" or "No" for each statement.

Has the attendee:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD)? ❒ Yes ❒ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? ❒ Yes ❒ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? ❒ Yes ❒ No
4. Had a significant event that continues to affect the attendee's life? (death in the family, divorce, adoption, new sibling, etc.) ❒ Yes ❒ No

Please explain "Yes" answers in the space below, noting the number of the questions.

What have we forgotten to ask? Please provide any additional information about the attendee's health that you think important or that may affect the attendee's ability to fully participate in the camp program. Attach additional information, if needed.

Consent to participate in camp: Please check one.

❒ I consent to the attendee's full participation in camp activities. I do not believe that any conditions listed in this Health Form increase the risk to the attendee of camp activities beyond what is normal and acceptable to me.

❒ I do not consent to the attendee's full participation in camp activities. I believe certain conditions listed in this Health Form may increase risk to the attendee of camp activities beyond what is normal and acceptable to me.

Authorization for Healthcare and Photo/Video Release

This Health Form accurately reflects the health of the attendee. I authorize Camp staff, medical providers (including physicians and EMTs) and/or my emergency contacts to authorize medical care and treatment, including invasive tests and/or surgery, for the attendee as any of them believe is reasonably necessary for the attendee's health and safety if I cannot be reached immediately. On behalf of the attendee, and his/her family, I release Camp KidJam, The reThink Group, Inc., and their employees, interns, directors, contractors, volunteers and all medical providers ("Camp Parties"), to the maximum extent legally permitted, from all claims arising from the attendee's medical care or treatment and I indemnify the Camp Parties from any claims, costs, damages, expenses or losses. I authorize information on this form to be photocopied and/or shared with Camp Parties. I authorize the attendee's health-care providers to discuss and/or copy the attendee's health-care records for Camp Parties. I understand that the attendee may be photographed or video taped during camp and that these images may be used in promotional materials.

Signature of attendee: ______________________________ Date: ____________
(if over 18 years of age)

Signature of parent/legal guardian: ______________________________ Date: ____________

Relationship to attendee: ______________________________

Parents/Guardians: STOP here. The rest of this form is to be completed at camp. Keep a copy of this form for your records.

CAMP KIDJAM

Health Form

Name: ____
First Middle Last

❐ Male ❐ Female Birth Date: ______________

Provider Notes: (Date/time/treatment given/initials)