Office Use Only Program_____ Dates_____ Last Name, First Initial

Camp of the Cross Ministries 2018 Summer Health Form

PO Box 1257 Garrison, ND 58540 (701) 337-2246 info@campofthecross.com

This form must be returned to the camp no later than two weeks before your session begins.
Please print in black or blue ink.

Name_____ Birth date___ /___/___ Grade Entering_____ Sex (Circle) Female/Male

Parent's Full Name(s)_____Family Email_____

Address_____ City_____ State_____ Zip_____

Phone # (Home)_____ Cell Phone_____

Work (Mother)_____ Work (Father)_____

If parental guardians are not available in case of emergency, please notify:

Name_____ Relationship _____ Phone #_____

Allergies

Please specify if you camper has any of the following allergies:

Medication _____
Food _____
Insects _____
Plants _____
Other _____

Swimming Ability

_____Non-swimmer
_____Beginner (avoids deep water)
_____Intermediate (comfortable in deep water)

Health History (If the child has **had** any of the following, please mark with an **"X"**. Use **"N"** if camper has **now**.)

_____ADD	_____Anorexia/Bulimia	_____Appendicitis	_____Arthritis
_____Asthma	_____Autism Spectrum Disorder	_____Behavior Challenges	_____Constipation
_____Diarrhea	_____Depression	_____Diabetes	_____Ear infections
_____Eczema	_____Fainting	_____Headaches	_____Hepatitis
_____Nervousness	_____Ulcers	_____Hay fever	_____Sinus infections
_____Bed-wetting	_____Sleep walking	_____Homesickness	_____Menstrual cramps
_____Chicken Pox	_____Measles	_____German measles	_____Mumps
_____Rheumatic fever	_____Bleeding/clotting disorders	_____High blood pressure	

_____Heart problems (Please describe) _____
_____Seizures (Please describe) _____

Other illness or needs that may affect camp life _____
Surgeries or serious illness and dates _____
Dietary concerns or restrictions _____
Physical activity restrictions _____

Females: Has this person menstruated? **YES NO** If no, has this been discussed? **YES NO**

Medications:

May over-the-counter medications be administered if needed (i.e. Tylenol or Tums)? YES NO

Please list any medications, including dosage and directions. _____
_____
_____
_____

Health Insurance Policy #_____ Child's Physician_____ Clinic_____
Clinic Phone Number: _____

Immunizations - The following information is mandatory. Do not use "current" or "up-to-date."

Required Vaccines - Enter Month/Year for each immunization given.

Vaccine Type	1st	2nd	3rd	4th	5th
Dta/DTP/DT (Diphtheria-Tetnus-Pertussis)					
Hib (Haemophilus influenza type b)					
IPV/OPV (Polio)					
MMR (Measles-Mumps-Rubella)					
Td Booster (Tetanus-Diphtheria)					

Recommend Vaccines - Not Required.

Varicella (Chicken Pox)					
Hepatitis B					

Please attach a separate sheet if there is any further information about your camper you wish to share to help us ensure your camper has a successful time participating in Camp of the Cross Ministries' programs.

My child has permission to participate in all aspects of the program at Camp of the Cross Ministries except as noted. I understand that every effort will be made to contact me if my child needs emergency medical-surgical treatment. I hereby give my permission to the medical personnel selected by the Camp of the Cross Ministries or its appointed representative to secure proper treatment; to hospitalize; to order injection, anesthesia, x-ray, or surgery for my child as named above; and to arrange for or provide necessary related transportation. I understand that my insurance has primary coverage and Camp of the Cross Ministries insurance is secondary. I give my approval to photocopy this form for use out of camp. I also give permission for pictures or video taken of my child to be used for promotion.

Parent or Guardian Signature _____ Date _____