



Name: Last _____ First _____ MI _____

Dates of Camp Attendance _____
mm/dd/yyyy

**Health History and Examination
Form for Campers and other Guests of Mt. Cross Ministries**

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care.

Health history must be filled out by parents/guardians of minors or by adults themselves. Update required annually.

Name _____ Birth date _____ Gender: Male Female
Last First Middle mm /dd/ yy

Home Address _____
Street & Number City State ZIP

Parent or Guardian _____ Phone (_____) _____

Home Address _____
(if different from above) Street & Number City State ZIP

Other Parent or Guardian or Emergency Contact _____

Home Address _____ Phone _____
Street & Number City State ZIP

If not available during emergency, notify _____

Home Address _____ Phone _____
Street & Number City State ZIP

Important – These Boxes must be complete for attendance

Parent/Guardian Authorization: This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a “need to know” basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child’s health record from providers who treat my child and these providers may talk with the program’s staff about my child’s health status.

Signature of parent/guardian or adult camper/staffer _____

Printed Name _____ Date _____

I also understand and agree to abide by any restrictions placed on my participation in any camp activities.

Signature of minor or adult camper/staffer _____ Date _____

Mt. Cross Health Form
This form is due no later than 2 weeks before check-in at Mt. Cross. You may mail it to:
P.O. Box 387
Felton, CA 95018
mtcross@mtcross.org

Health History

The Following information must be filled in by the parent/guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp.

Please provide complete information so that the camp can be aware of your needs.

Allergies List all Known Describe Reaction and Management of the Reaction

Medication Allergies (list)

Food Allergies (list)

Other Allergies (list) –include insect stings, hay fever, asthma, animal dander, etc.

Medications being taken

Please List ALL medications (including over the counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescribed drug), the name of the medication, the dosage, and the frequency of administration.

This person takes no medications on a routine basis.

This person takes medications as follows:

Med #1 _____ Dosage _____ Specific times each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific times each day _____

Reason for taking _____

Med #3 _____ Dosage _____ Specific times each day _____

Reason for taking _____

Any reactions to these medications? _____

What are the effects if missed? _____

Identify any medications taken during the school year that participant does/may not take during the summer: _____

Dietary Restrictions (Please check one and describe as necessary)

Participant eats a regular diet

Participant eats a vegetarian diet

Participant eats a special diet described below:

Activity Restrictions (e.g. what cannot be done, what adaptations or limitations are necessary)

I have reviewed the program and activities of the camp and feel the camper can participate without restrictions

I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations:

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mm/dd/yyyy

General Questions (Please check appropriate box and explain "yes" answers below.)

Has/does the participant:

Yes/No

Yes/No

- | | |
|--|---|
| 1. <input type="checkbox"/> <input type="checkbox"/> Had any recent injury, illness or infectious disease? | 16. <input type="checkbox"/> <input type="checkbox"/> Ever had back problems? |
| 2. <input type="checkbox"/> <input type="checkbox"/> Have a chronic or recurring illness/condition? | 17. <input type="checkbox"/> <input type="checkbox"/> Ever had problems with joints? |
| 3. <input type="checkbox"/> <input type="checkbox"/> Ever been hospitalized? | 18. <input type="checkbox"/> <input type="checkbox"/> Have an orthodontic appliance being brought to camp? |
| 4. <input type="checkbox"/> <input type="checkbox"/> Ever had surgery? | 19. <input type="checkbox"/> <input type="checkbox"/> Have any skin problems (itching, rash, acne)? |
| 5. <input type="checkbox"/> <input type="checkbox"/> Have frequent headaches? | 20. <input type="checkbox"/> <input type="checkbox"/> Have diabetes? |
| 6. <input type="checkbox"/> <input type="checkbox"/> Ever had a head injury? | 21. <input type="checkbox"/> <input type="checkbox"/> Have asthma? |
| 7. <input type="checkbox"/> <input type="checkbox"/> Ever been knocked unconscious? | 22. <input type="checkbox"/> <input type="checkbox"/> Had mononucleosis in the past 12 months? |
| 8. <input type="checkbox"/> <input type="checkbox"/> Wear glasses, contacts or protective eyewear? | 23. <input type="checkbox"/> <input type="checkbox"/> Had problems with diarrhea/constipation? |
| 9. <input type="checkbox"/> <input type="checkbox"/> Ever had frequent ear infections? | 24. <input type="checkbox"/> <input type="checkbox"/> Have problems with sleepwalking? |
| 10. <input type="checkbox"/> <input type="checkbox"/> Ever passed out during or after exercise? | 25. <input type="checkbox"/> <input type="checkbox"/> If female, have an abnormal menstrual history? |
| 11. <input type="checkbox"/> <input type="checkbox"/> Ever been dizzy during or after exercise? | 26. <input type="checkbox"/> <input type="checkbox"/> Have a history of bed wetting? |
| 12. <input type="checkbox"/> <input type="checkbox"/> Ever had seizures? | 27. <input type="checkbox"/> <input type="checkbox"/> Ever had an eating disorder? |
| 13. <input type="checkbox"/> <input type="checkbox"/> Ever had chest pain during or after exercise? | 28. <input type="checkbox"/> <input type="checkbox"/> Ever been treated for ADD or AD/HD? |
| 14. <input type="checkbox"/> <input type="checkbox"/> Ever had high blood pressure? | 29. <input type="checkbox"/> <input type="checkbox"/> Ever had emotional difficulties for which professional help was sought? |
| 15. <input type="checkbox"/> <input type="checkbox"/> Ever been diagnosed with a hurt mummer? | |

Please explain any "yes" answers, noting the number of the questions.

Immunizations: You may attach photocopies

Immunizations with an asterisk (*) must be current for participant to attend camp.

Which of the following has the participant had?

- Measles
- Chicken Pox
- German measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

TB Mantoux Test

Date of Last Test _____

Result: Positive Negative

Please give the month and year of the participant's immunizations or attach this person's immunization record:

Vaccine:	Month/Year
*DTaP	_____
TD (tetanus/diphtheria)	_____
*Tetanus Booster	_____
*Polio	_____
*M M R	_____
or measles	_____
or mumps	_____
or Rubella	_____
Haemophilus influenza B	_____
Hepatitis B	_____
Hepatitis A	_____
Varicella (chicken pox)	_____
Pneumococcal (PCV)	_____
Meningococcal meningitis (MCV4)	_____

What have we forgotten to ask? Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

Name of Family Physician _____ Phone _____
Address _____

Name of Family dentist/orthodontist _____ Phone _____
Address _____

Health Care Recommendations by Licensed Medical Personnel (Required)

I examined this individual on _____. (It is recommended that campers have an exam within 24 months of camp attendance, may be filled out by any medical personnel.)

BP _____ Weight _____ Height _____

In my opinion, the above applicant: is able to participate in an active camp program
 is **NOT** able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

Recommendations and Restrictions at Camp:

Treatment to be continued at camp

Medications to be administered at camp (name, dosage, frequency)

Any medically prescribed meal plan or dietary restrictions:

Known Allergies:

Description of any limitation or restriction on camp activities

Additional information for health care staff at the camp

Signature of Licensed Medical Personnel _____

Printed Name _____ Title _____

Address _____

Phone _____ Date _____

Screening Record for Camp Use Only

Date Screened _____

Time _____ am/pm

Updates/Additions to health history noted ____ yes ____ no ____ none required

Current health needs identified _____

Observational Notes _____

Screened by _____