Health History Form

Adult Campers

Camp and Retreat Ministries
Oregon-Idaho Conference
1505 SW 18th Avenue
Portland, OR 97201

Dates of Camp Attendance _____

Name of Camp Session or Event _____

Site: *(Circle one)* **Collins Retreat Center Camp Latgawa Camp Magruder Suttle Lake Camp Sawtooth Camp Wallowa Lake Camp**

Mail this form to the Camping Office
at least 10 days before the first day of the event.

This completed form (all pages) should be sent to the camping office at least 10 days prior to your event. Attach additional pages if needed. Any changes to this form should be provided to camp health personnel ***in writing*** upon participant's arrival at camp.

Camper's Name _____ Birthdate _____

Preferred pronoun(s) _____

Address _____ Gender ☐ Male ☐ Female ☐ X

City _____ State ___ Zip _____ Email _____ Phone _____

In case of emergency, notify: _____

Address _____ Phone _____

City _____ State _____ Zip _____ Relationship to Camper _____

Cabin Assignment (For Camp Staff Use Only) _____

General Information Height (Feet and Inches): _____ Weight (Lbs): _____

ALLERGIES AND DIETARY RESTRICTIONS

Do you have any allergies?

Yes No

If Yes, circle one: Food Drug Environmental/other

Allergic to: _____

Allergic reaction details:

_____

_____

Do you require an EpiPen?

Yes No

Please provide details about your anaphylaxis, including description of the reaction

_____

_____

_____

Do you have any dietary restrictions? If yes, please provide details below.

Yes No

MEDICATIONS

Will you be taking any medications while at camp? Yes No

Please attach additional sheets as necessary. Medicine must be brought to camp in its original packaging.

Medication: _____ Dose: _____

Times taken each day: ___Breakfast ___Lunch ___Snack ___Dinner ___Before Bed ___As Needed

Please explain the reason for the medication and any notes on giving this medication.

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Times taken each day: ___Breakfast ___Lunch ___Snack ___Dinner ___Before Bed ___As Needed

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IMMUNIZATIONS

Please list the date of your <u>most recent</u> vaccination or booster, if any, for the following:

Vaccine	Immunized (Y/N)	Date of most recent vaccination/booster (if known)
COVID-19 (not required but recommended if eligible)		Please enter dates of both doses or note if received the one-dose Johnson & Johnson vaccine (with date).
TB		
Diphtheria/Pertussis/Tetanus (DTaP)		
Haemophilus Influenza B		
Hepatitis A		
Hepatitis B		
Pneumococcal (PCV)		
Meningococcal Meningitis (MCV4)		
Influenza (Flu)		

If you have not been fully immunized, please explain.

HEALTH HISTORY

Have you had any operations? (Circle Yes or No). If Yes, please explain the operation(s), including date(s). Yes No

Have you ever been hospitalized or had a serious injury? (Circle Yes or No). If Yes, please explain the reason(s) for hospitalization(s) or the serious injury(ies) and the dates they occurred. Yes No

Have you been exposed to any communicable diseases within the last 3 months? If Yes, please explain what disease(s) you have been exposed to, and when the exposure occurred. Yes No

Do you have any restrictions on activity? If yes, please explain what activities must be restricted and list any special accommodations that should be made. Yes No

Will you require any special assistance while at camp? If yes, please explain what assistance will be required. Yes No

Please list any health information regarding current or on-going physical, mental, emotional, social health, developmental, or psychological conditions the camp should know.

Is there anything you would like to discuss with the camp medical staff?

DOCTOR INFORMATION

Family Doctor (write NONE if you don't have one)

_____

Phone: _____

Family Dentist (enter NONE if you don't have one)

_____

Phone: _____

HEALTH INSURANCE INFORMATION

(Write N/A if you don't have insurance)

Full Name of Policy Holder: _____

Insurance Company / Plan Name: _____ **Health Insurance Policy Number:** _____

Insurance Group Name or Number: _____

PERMISSION TO PROVIDE NECESSARY TREATMENT OR EMERGENCY CARE:

I hereby certify that this information is correct. In case of medical emergency, I understand that every effort will be made to contact the emergency contact I have provided. In the event they cannot be reached, I hereby give permission to the medical personnel selected by the camp to secure and administer treatment, including hospitalization, and to provide or arrange necessary related transportation for me. Medical providers are authorized to disclose protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health-care provider involved in providing medical care. I agree to the release of any records necessary for insurance purposes. A printed version of this completed health form may be photocopied for trips out of camp.

Your signature below confirms that you have read the medical waiver, that you understand it, and that you agree to be bound by it. If you do not agree to this waiver, you will not be able to attend camp.

Your Full Name: _____ Date: _____

Signature: _____

SOCIAL MEDIA POLICY

I confirm I have read and understand the Social Media Policy of Camp and Retreat Ministries of the Oregon-Idaho Conference. For more details: https://www.gocamping.org/readysetgotocamp.

If you do not sign, you will not be able to attend camp.

Your Full Name:
_____

Signature:
_____

Date:
_____

PHOTO RELEASE

I give permission for my photo, oral interview or written material to be used in advertising of the camp or camping program. For more details: https://www.gocamping.org/readysetgotocamp

(Do not sign if you do not give permission.)

Your Full Name:
_____

Signature:
_____

Date:
_____