Summer Camping Program
HEALTH HISTORY FORM

FOR INFORMATION CONTACT:
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This side to be filled in by parents/guardian of minors or by adult participants themselves.

Name _____ Birthdate _____ Sex _____ Age _____

Parent or Guardian_____ Cell _____

Home Address _____ Phone _____

Business Address_____ Phone _____

Second Parent and/or Guardian or Emergency Contact _____

Home Address _____ Phone _____

Business Address _____ Phone _____

If not available in an emergency, notify _____ Phone _____

Address _____ Phone _____

Health History (check approximate dates)

Diseases
Chicken Pox _____ Measles _____ German Measles _____ Mumps _____

Are you allergic to any
Drugs _____ Foods _____ Insect Bites _____ Other _____

Present medical problems or tendencies (check where applicable)

Has this participant had a DPT shot? _____ Date last tetanus shot_____

Has this participant ever required any psychiatric counseling or hospitalization? _____

List all operations or serious injuries (dates)_____

_____

List all disabilities, chronic and recurring illnesses_____

List all dietary limitations_____

Sinusitis _____	Diabetes _____	Frequent Colds _____	Heart Trouble _____
Convulsions _____	Fainting _____	Kidney Trouble _____	Frequent Sore Throat _____
Sensitive Skin _____	Sleep Walking _____	Contact Lenses _____	Epilepsy _____
Bronchitis _____	Stomach upset _____	Ear Infections _____	Bed Wetting _____

Other _____

List all other diseases or illnesses not listed above_____

Name of dentist/orthodontist _____ Phone _____

Name of family physician _____ Phone _____

Date of last physical examination _____

Suggestions or health related information for camp personnel_____

There has been no changes in my health or physical abilities in the last year _____yes _____ no

Please explain _____

_____

IMPORTANT - THIS BOX MUST BE COMPLETED FOR ATTENDANCE

This health history is complete and correct, and the person listed below has permission to engage in all prescribed activities except as noted. I hereby give permission to the program staff:

1. To provide ongoing health care.
2. To select medical personnel and to order x-rays or routine tests or treatment for the person listed below.

To my knowledge this participant has not been exposed to a contagious or infectious disease within two weeks prior to this activity. In the event of a medical emergency and I cannot be contacted , I hereby give permission to the Camp Coordinator to select a physician and/or hospital for my child's care. I hereby also give the hospital and/or physician, as selected by the Camp Coordinator, my permission to hospitalize, treat and to order, injections, anesthesia medical treatment and/or surgery for my child whose name is:

_____

Signature _____
Date _____
Relationship _____
List medications to be taken, dosage and/or
frequency of use: _____
_____
_____

Witness_____
Notary _____
Date _____
Do you have medical/hospital insurance? _____
Name of Insurer _____
_____
Group or policy # _____

CAMPER INFORMATION

Name _____ Age at Camp _____ Birth Date_____
Parent(s) _____ Vocation _____
_____ Vocation _____
Address _____ City _____ Zip _____
Brothers or sisters (names and ages) _____
Church _____ Association _____ Pastor _____
School _____ Grade _____
Organization Memberships _____
Hobbies _____
Talents _____
Are you a member of an RA Chapter? _____ Challenger? _____ Have you made a profession of faith in Jesus Christ?_____
Have you been to a camp before? _____ If so, where?_____ Do you swim? _____
What do you hope attending Camp Kaleo will do for you? _____
_____
What meaningful experiences do you hope your child will gain from attending Camp Kaleo? _____
_____
_____
_____
_____

Georgia Baptist Mission Board
Georgia Baptist Men's Ministry