**Camp Burton**
*14282 Butternut Road*
*Burton, Ohio 44021*
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Camping Ministry of Converge MidAtlantic

## CAMP BURTON HEALTH FORM

*The following information is required so that we can work together with you to better meet the physical and emotional needs of the camper. Please fill in ALL requested information.* ***Note that it is not complete without your signature in the appropriate places. Please bring the completed health form with you when you check your child in for camp. State camping laws and policies of emergency care by doctors and hospitals dictate that we cannot accept a camper without this completed form (including signatures).***

**Name** _____ **Birth date** _____ **Sex** _____ **Age** _____
*last/first/initial*

**Parent or Guardian** _____

Home Address _____
*street & number* *city* *state* *zip*

Home Phone _____ Business Phone _____ Mobile/Pager _____
*area/number* *area/number/ext* *area/number*

**Second Parent or Guardian** _____

Home Address _____
*street & number* *city* *state* *zip*

Home Phone _____ Business Phone _____ Mobile/Pager _____
*area/number* *area/number/ext* *area/number*

Name of physician: _____ Phone _____

Name of dentist/orthodontist: _____ Phone _____

**Health History** (Attach additional pages if necessary, especially if multiple medications. Please note that this information will be shared with the camper's counselor.)

| **Diseases** | **Hospitalizations** | **Allergies** (including FOOD, Medication and Environmental) | | **Medications** (list dosage and frequency of prescribed and over the counter medications) | |
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Has this camper ever required any psychiatric counseling or hospitalization? _____

Any specific activities to be encouraged or limited by physician's advice: _____

Dietary modifications: _____

Special conditions to watch for, such as ALLERGY (reactions to food, Penicillin or other drugs) bedwetting, fainting, sleepwalking, behavioral problems, dietary restrictions, etc. _____

Should the camper's activity be restricted because of any physical defect or illness? _____

If "yes" explain degree of restriction: _____

_____

**Immunization History**

*Required immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster doses:*

| Vaccines | Year of basic immunization | Year of last booster |
|---|---|---|
| Diphtheria<br>Pertussis (Whooping Cough) ( DPT)<br>Tetanus | 1<br>2<br>3 | 1<br>2 |
| Tetanus<br>Diphtheria (TD) | | |
| Tetanus | | |
| Oral Polio (Sabin) TOPV | | |
| Injectable Polio (Salk) | | |
| Measles (hard measles, red measles, Rubella) | | |
| Mumps | | |
| Rubella (German measles, 3-day measles) | | |
| Other | | |
| Tuberculin test given _____ (most recent) | | |

**Health Insurance**

As part of our desire to be good stewards of the funds entrusted to us by God – and to keep our costs as reasonable as possible – Camp Burton has implemented a camper/worker Health and Accident Insurance plan.

When one of our camper/workers is covered by their family health insurance policy, and this policy provides benefits paying for medical treatment resulting from an injury or illness occurring at Camp Burton, the camper/worker shall be covered by that policy while at Camp Burton. Our purpose is to avoid "dual insurance coverage". If your insurance policy does include coverage for your son or daughter, please check the appropriate box below and complete the necessary information.

_____ My son/daughter **is covered** under our family health insurance policy.

Policyholder's name _____

Insurance company name _____

Address _____

City _____ State _____ Zip _____

Policy identification number _____

Camper/Worker name _____

_____ My son/daughter **is NOT covered** under our family health insurance policy.

**Parent's signature** _____

**IMPORTANT—THIS BOX MUST BE COMPLETED/SIGNED/WITNESSED FOR ATTENDANCE**

I have read and understand this complete health form. This health history is correct so far as I know and the person listed above has permission to engage in all prescribed camp activities except as noted. I hereby give permission to the camp;

1. To provide ongoing health care and first aid.
2. To select medical personnel to provide emergency transportation, and to order X-rays or routine tests or treatment for the person listed above.
3. Administer and/or supervise the self-administration of prescribed medications and treatments including routine medications and treatments as authorized by the camper's personal physician or the camp physician.

**I do not wish the camp personnel to do/administer the following:**

**Emergency Authorization: In the event I cannot be reached in an emergency, I hereby give my permission to the physician selected by the camp director to hospitalize, secure proper emergency treatment for, and to order injection and/or anesthesia and/or surgery for the person named above. This form may be photocopied.**

**Signature of parent or guardian or adult camper/staffer**: _____

**Witness to your signature**_____ Date _____