HEALTH HISTORY: [MAY BE FILLED OUT BY PARENT]

CAMPER'S NAME: _____

RECENT ILLNESS, HOSPITALIZATION OR OPERATIONS [INCLUDE DATES]:
_____
_____

CHRONIC OR RECURRING ILLNESS: _____
_____

MEDICATIONS: [Be sure and bring all along with you. They should be accurately labeled as to name, dosage, when they are taken, and prescribing physician's name]:
_____
_____
_____

PLEASE CHECK ANY WHICH APPLY TO THE CAMPER:

□ Asthma □ ADHD/ADD
□ Seizures Date of last seizure: _____
□Heart Disease □ Ear infections
□ Visual Deficit □ Diabetes
□ Hearing Deficit □ Speech Problem
□ Fainting □ Mental Health
__ Do you use an inhaler? __yes __ no **If yes, please bring one to camp**

Allergies:

□ Hay fever □ Insect Stings
□ Latex □ Peanuts
□ Medications: _____
□ Other Foods: _____
□ **Does camper carry an Epi-pen?** __YES __NO [If yes, please send the Epi-pen with them and ensure they know how to use it]

Other dietary restrictions: _____

Special Needs (We encourage your camper to be as independent as possible. However we understand that your camper may need some assistance. Please complete the section below to help us know about any assistance that may be needed.)

Bathing:

□ No assistance needed □ Needs assistance undressing/dressing
□ Needs assistance getting in/out of shower □ Needs assistance washing hair
□ Needs assistance with brushing teeth □ Needs assistance with combing hair
Other_____

Dressing:

□ No assistance needed
□ Needs assistance with shirts
□ Needs assistance with socks and shoes
□ Needs assistance with pants
□ Needs assistance with buttons/zippers
□ Other _____

Toileting:

□ No assistance needed
□ Needs assistance with transferring
□ Needs assistance with wiping
□ Other _____

Other Assistance: _____

Physician & Insurance Information [A copy of Insurance Card must be included with application]

Medical/Hospital Plan: _____ Policy or Group #: _____
Policyholder's first & last name:_____
Employer:_____
Primary Physician Name:_____ Phone: _____
Family Dentist's Name: _____ Phone: _____

PLEASE ATTACH IMMUNIZATION RECORD. All immunizations must be up to date.

I, THE UNDERSIGNED PARENT OR GUARDIAN, ATTEST HEREBY THAT MY CHILD/WARD HAS NO MEDICAL HISTORYTHAT ELIMINATES HIS PARTICIPATION IN THIS CAMP PROGRAM. I ALSO ATTEST THAT THE CHILD'S MEDICAL DOCTOR DID NOT PROHIBIT HIS/HER PARTICIPATION.

_____
SIGNATURE

PARENTAL RELEASE:
I HEREBY RELEASE THE STAFF OF ADVENTURE CAMP AND HIGHROADS PROGRAM CENTER FROM ANY RESPONSIBILITY FOR ANY INJURY OR ILLNESS DERIVED FROM PARTICIPATION IN THE ADVENTURE CAMP PROGRAM. I GRANT THE CAMP STAFF PERMISSION TO OBTAIN EMERGENCY MEDICAL TREATMENT IF REQUIRED. I HEREBY GRANT PERMISSION TO THE BOARD OF DIRECTORS OF THE CAMP TO USE ANY PICTURES OF MY CHILD TAKEN IN CONNECTION WITH CAMP ACTIVITIES FOR EDUCATION OR PUBLICITY PURPOSES.

_____ _____
SIGNATURE DATE