

Health History Form Operation Purple® Camp Ellensburg

All campers: confidential information, please print clearly (in ink)

Circle Camp Attending:	Session 1 (June 20-25)	Session (August 1-6)	Session 3 (August 8-13)				
This completed form should be sent in to the Lazy F office by June 1st for session 1 (June 20-25) or July 1st for session 2 (August 1-6) and session 3 (August 8-13) so that the camp staff can be aware of your needs. Attach additional pages if needed.		Mail this form to the address below: Operation Purple® Camp Lazy F Camp and Retreat Center 16170 Manastash Road Ellensburg, WA 98926					
Camper's Name:	Birthdate (M/D/YYYY)						
Address	Gender (circle one) Male Female						
City/State:	Zip:						
Parent/Guardian Name (s):							
Evening phone: ()	Day/Work Phone ()	Cell Phone ()					
Address (if different)		City/State:	Zip:				
Emergency Contact, (other than parent/guardian):		Phone ()					
Address (if different)		City/State:	Zip:				
Cell Phone: ()	Relationship to Camper:						
Does camper have any known allergies? (circle one) YES NO							
Allergies to Medications:							
Food Allergies:							
Other Allergies:							
List any dietary restrictions:							
Health History (WITHIN THE LAST THREE YEARS, CHECK ANY THAT APPLY):							
<input type="checkbox"/>	Epilepsy or seizures	<input type="checkbox"/>	Frequent sore throats	<input type="checkbox"/>	Black pain or strain	<input type="checkbox"/>	Frequent ear infections
<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Alcohol/drug addiction	<input type="checkbox"/>	Menstrual problems	<input type="checkbox"/>	Bed-wetting
<input type="checkbox"/>	Attention Deficit Disorder	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	Diabetes (type 1 or 2)
<input type="checkbox"/>	Tobacco usage	<input type="checkbox"/>	Eating disorders	<input type="checkbox"/>	Nightmares	<input type="checkbox"/>	Hyperventilation
<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>	Sleep walking	<input type="checkbox"/>	Severe allergic reaction	<input type="checkbox"/>	Self-mutilation
Other: _____							
Pertinent Past Medical Treatment: _____							
Is camper presently taking or using any type of medication(s) or drug(s)? (circle one) YES NO							
<i>(If "yes" you will need to complete the "Permission to Administer Medications and Administration of Medication" form on opposite side)</i>							
PLEASE PROVIDE A RECORD OF IMMUNIZATIONS							
Is the camper on all immunizations needed for school? YES NO		Date of last tetanus shot		Blood Type:			
Does the camper have a health condition (e.g. allergies, chronic conditions) or special circumstances which may affect program participation, special housing need, or anything we ought to now prior to emergency treatment? (circle one) YES NO							
Family Medical Insurance: YES NO		Name of Insured:					
Carrier:				Group #:		Phone: ()	
Name of Family Physician:						Phone: ()	
<p><i>My child has permission to take part in all camp activities under supervision unless limitations are noted above, and I agree that the camp or camp personnel will not be held responsible for accidents arising there from. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for my child. I either have appropriate insurance or, in its absence, agree to pay all the costs of medical services as may be incurred on my camper's. In an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed health form may be photocopied for trips out of camp.</i></p> <p><i>I, the undersigned parent/guardian, give permission for the above named camper to participate in the camp indicated above. I recognize and acknowledge that camping activity can involve certain hazards, including, but not limited to, illness, injury, and accidents, and release The United Methodist Church from liability.</i></p> <p>I GIVE PERMISSION FOR: -Photocopying of health history form -Photos/video to be used in future publicity -Camper's name, and e-mail address to be included in an address list</p>							
Signature of parent/guardian						Date:	

Permission to Administer Medications and Administration of Medication *Operation Purple*[®] Camps

I give my permission to the Camp Health Care Provider or his/her designate to give the following medications (or their generic equivalents) to my child, _____, in accordance with recommended package dosing for the specific indications below. These medications are available at camps and need not be brought by participants.

Tyenol: Mild fever or discomforts	YES	NO	Benadryl: Allergy symptoms	YES	NO
	_____	_____		_____	_____
Ibuprofen: Mild fever or discomforts			Sudafed: Allergy symptoms		
	_____	_____		_____	_____
Throat Lozenges: coughing/sore throat			Antacid: Upset stomach		
	_____	_____		_____	_____
Topical Creams: itching, sunburn or insect bites			Anti-diarrheal: for diarrhea		
	_____	_____		_____	_____
Permission to follow recommendations by Washington Poison Center or Idaho Poison Control:				_____	_____

Please add an additional page if needed.	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun.
Medication: Dosage: Time to give: Reason for taking:							
Medication: Dosage: Time to give: Reason for taking:							
Medication: Dosage: Time to give: Reason for taking:							
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Medication: Dosage: Time to give: Reason for taking:							

If your child will be on a “med holiday”, we ask that you please send the medication to camp. If it appears that your camper would benefit from being on their medication, we will have the Camp Health Care Provider be in contact with you.

Identify any medications that the camper does not/may not take during this camp:

IMPORTANT INFORMATION: PLEASE KEEP ALL MEDICATION (prescription AND over-the-counter) IN THE ORIGINAL CONTAINER that identifies; the prescribing physician (if appropriate), the name of the medication, the dosage, and the frequency of administration. All medications must be checked in to camp staff upon arrival.

I hereby authorize the Health Care Provider for Lazy F Camps to administer the above listed medications to my child/dependent during their time at camp. I have given the Health Care Provider dosage and administration instructions.

Note: The Camp personnel will notify you if your child displays the following symptoms:

- *Any illness that persists longer than 24 hours; including fevers, coughs, excess expulsion of bodily fluids, allergic reactions, severe tiredness
- *Any injury that causes severe prolonged pain, discoloration and/or swelling
- *Any condition that cannot be sufficiently treated by camp personnel
- *Any condition requiring transport to other medical services

Parent/Guardian Signature:	Date:
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Upon Camper	Health History Form Verified	Date:	By:	(initial)
Check In	Administration of Meds rec'd	Date:	By:	(initial)