



Name _____
Dates of Camp Attendance _____

Health History and Examination Form For Campers and other Guests of Mt. Cross Ministries

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Health history must be filled out by parents/guardians of minors or by adults themselves. Update required annually.

Name _____ Birth date _____

Age at Camp _____ Gender: _____ Male _____ Female _____ SS# of participant _____

Home Address _____
Street & Number City State ZIP

Name of Parent or Guardian _____ Phone (____) _____

Home Address _____
(if different from above) Street & Number City State ZIP

Business Address _____ Phone(____) _____
Street & Number City State ZIP

Other Parent or Guardian or Emergency Contact _____

Home Address _____ Phone _____
Street & Number City State ZIP

Business _____ Phone _____
Street & Number City State ZIP

If not available during emergency, notify _____

Home Address _____ Phone _____
Street & Number City State ZIP

**Photocopy of front and back of health insurance card must be attached to this form.
Important – These Boxes must be complete for attendance**

Parent/Guardian Authorization: This health history is correct and complete to the best of my knowledge. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed or over the counter 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 me/my child.
In the event that I cannot be reached 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 form maybe photocopied for trips out of camp.
It is recommended that this camper has been examined by medical personnel in the past 24 months.
Signature of parent/guardian or adult camper/staffer _____
Printed Name _____ Date _____

I also understand and agree to abide by any restrictions placed on my participation in any camp activities.
Signature of minor or adult camper/staffer _____ Date _____

Mt. Cross Health Form
This form is due upon check in at Mt. Cross or you may send in at any time to:
**P.O. Box 387
Felton, CA 95018
mtcross@mtcross.org**

Name _____

Dates of Camp Attendance _____

Health History

The Following information **must be filled in** by the parent/guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. **Please provide complete information so that the camp can be aware of your needs.**

Allergies List all Known Medication Allergies (list)

Describe Reaction and Management of the Reaction

Food Allergies (list)

Other Allergies (list) –include insect stings, hay fever, asthma, animal dander, etc.

Medications being taken

Please List ALL medications (including over the counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescribed drug), the name of the medication, the dosage, and the frequency of administration.

_____ This person takes no medications on a routine basis.

_____ This person takes medications as follows:

Med #1 _____ Dosage _____ Specific times each day _____
Reason for taking _____

Med #2 _____ Dosage _____ Specific times each day _____
Reason for taking _____

Med #3 _____ Dosage _____ Specific times each day _____
Reason for taking _____

Any reactions to these medications? _____

What are the effects if missed? _____

Identify any medications taken during the school year that participant does/may not take during the summer: _____

Explain any dietary Restrictions (The following restrictions apply to this individual.)

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

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General Questions (Explain yes answers below)

Has/does the participant:

- | | Yes/No | | Yes/No |
|--|--------|---|--------|
| 1. Had any recent injury, illness or infectious disease? | | 16. Ever had back problems? | |
| 2. Have a chronic or recurring illness/condition? | | 17. Ever had problems with joints? | |
| 3. Ever been hospitalized? | | 18. Have an orthodontic appliance being brought to camp? | |
| 4. Ever had surgery? | | 19. Have any skin problems (itching, rash, acne)? | |
| 5. Have frequent headaches? | | 20. Have diabetes? | |
| 6. Ever had a head injury? | | 21. Have asthma? | |
| 7. Ever been knocked unconscious? | | 22. Had mononucleosis in the past 12 months? | |
| 8. Wear glasses, contacts or protective eyewear? | | 23. Had problems with diarrhea/constipation? | |
| 9. Ever had frequent ear infections? | | 24. Have problems with sleepwalking/ | |
| 10. Ever passed out during or after exercise? | | 25. If female, have an abnormal menstrual history? | |
| 11. Ever been dizzy during or after exercise? | | 26. Have a history of bed wetting? | |
| 12. Ever had seizures? | | 27. Ever had an eating disorder? | |
| 13. Ever had chest pain during or after exercise? | | 28. Ever had emotional difficulties for which professional help was sought? | |
| 14. Ever had high blood pressure? | | | |
| 15. Ever been diagnosed with a hurt mummer? | | | |

Please explain any "yes" answers, noting the number of the questions.

Which of the following
 Has the participant had?

- Measles
- Chicken Pox
- German measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

TB Mantoux Test

Date of Last Test _____

Result: Positive Negative

Please list whether this person has had these immunizations:

Vaccine:	Date(s)
DTP	_____
TD (tetanus/diphtheria)	_____
Tetanus	_____
Polio	_____
M M R	_____
or measles	_____
or mumps	_____
or Rubella	_____
Haemophilus influenza B	_____
Hepatitis B	_____
Varicella (chicken pox)	_____

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

Name of Family Physician _____ Phone _____
 Address _____

Name of Family dentist/orthodontist _____ Phone _____
 Address _____

Name _____
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Health Care Recommendations by Licensed Medical Personnel

I examined this individual on _____. (It is recommended that campers have an exam within 24 months of camp attendance, may be filled out by any medical personnel.)

BP _____ Weight _____ Height _____

In my opinion, the above applicant: is able to participate in an active camp program
 is **NOT** able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

Recommendations and Restrictions at Camp:

Treatment to be continued at camp

Medications to be administered at camp (name, dosage, frequency)

Any medically prescribed meal plan or dietary restrictions:

Known Allergies:

Description of any limitation or restriction on camp activities

Additional information for health care staff at the camp

Signature of Licensed Medical Personnel _____	
Printed Name _____	Title _____
Address _____	
Phone _____	Date _____

Screening Record for Camp Use Only	
Date Screened _____	Time _____ am/pm
Updates/Additions to health history noted ____ yes ____ no ____ none required	
Current health needs identified _____	
Observational Notes _____	
Screened by _____	