

# Bethel Christian Camp Health Form

**We strive to make Bethel a safe place for our campers.** One way that we do that is by having you complete a health history for your child so that we may be better prepared in the event of an emergency. The health form is kept confidential and used by our health care staff (or emergency medical personnel). Some of the information that you provide on this sheet is a duplicate of information you have provided on your registration form. This is because this information will be kept on hand by the camp health care staff during your child's week at camp.

**Every camper NEEDS a completed health form to participate in any Bethel camp programs.**

**Please fill out this form as completely as possible.** Campers are not singled out, made to feel embarrassed or treated differently because of information gathered from the health form. Rather, the more we know ahead of time, the easier it is to help your child have a successful experience at camp. Thank you!

## Section 1 – Basic Contact Information

Camper Name (Last, First, Middle) \_\_\_\_\_

Birth date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_ Social Security # \_\_\_\_\_

Gender:  Male  Female

Camper Lives with:  Mother & Father  Mother  Father  Grandparent  Other \_\_\_\_\_

Mother/Guardian #1 Name \_\_\_\_\_

Day Phone \_\_\_\_\_ Night Phone \_\_\_\_\_

Day Phone is  Home  Work  Cell Night Phone is  Home  Work  Cell

Father/Guardian #2 Name \_\_\_\_\_

Day Phone \_\_\_\_\_ Night Phone \_\_\_\_\_

Day Phone is  Home  Work  Cell Night Phone is  Home  Work  Cell

Additional Emergency Contact (In case we can't reach YOU) \_\_\_\_\_

Relationship \_\_\_\_\_

Day Phone \_\_\_\_\_ Night Phone \_\_\_\_\_

Day Phone is  Home  Work  Cell Night Phone is  Home  Work  Cell

### Doctor Contact Information (if child is currently under treatment)

Family Physician Name \_\_\_\_\_ Phone \_\_\_\_\_

Dentist/Orthodontist Name \_\_\_\_\_ Phone \_\_\_\_\_

### If you will be traveling during your camper's stay at Bethel.

Please inform us in writing of any travel plans. Attach phone numbers, local relative names and numbers, and/or any other information that would assist us in contacting you in case of an emergency.

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## Section 2 – Insurance Information

Insurance Carrier \_\_\_\_\_ Group or Policy # \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Relationship to participant \_\_\_\_\_

Policy Holder's SS# or Insurance ID# \_\_\_\_\_

## Section 3a – Medications

Will Camper be taking medications while at camp?  Yes  No

(medications include prescription, over-the counter, vitamins, inhalers, etc)

If Child will be taking NO medication during their time at Bethel then please skip to **Section 3b – Restrictions and Instructions**

If camper will be taking medications while at camp, please list all (prescription and non-prescription). Include the medication name, prescribing physician, physicians' phone number, and the dosage instructions. Use an additional sheet if needed. You can download one here: <http://www.bethelchristiancamp.org/forms.htm>. When you check-in at camp, please provide all medications in their **original packaging** that identifies the prescribing physician (if prescription drug), the name of the medication, the dosage, and frequency of administration.

**Medication** \_\_\_\_\_ Dosage \_\_\_\_\_ Taken @ what times \_\_\_\_\_

Reason for Taking \_\_\_\_\_

Prescribing Physician \_\_\_\_\_ Phone \_\_\_\_\_

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Reason for Taking \_\_\_\_\_

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Reason for Taking \_\_\_\_\_

Prescribing Physician \_\_\_\_\_ Phone \_\_\_\_\_

### **Section 3b – Restrictions and Instructions**

#### **Special Instructions or Considerations for Minor Illness**

Unless specific instructions are provided camp health care staff will treat minor illnesses with over the counter medications. If illness persists, parents will be notified.

\_\_\_\_\_  
\_\_\_\_\_

#### **Special Dietary Needs**

\_\_\_\_\_  
\_\_\_\_\_

#### **Physical Activities to be Limited or Restricted while at Camp**

\_\_\_\_\_  
\_\_\_\_\_

#### **Anything else you think we should know**

\_\_\_\_\_  
\_\_\_\_\_

### **Section 4 – Allergies**

Camper does not have any Allergies (proceed to Section 5)

Camper is allergic or has an extreme reaction to:

1.Pollen and Dust  2.Poison Ivy/Oak  3.Bee Stings  4.Insect Stings  5.Food  6.Penicillin  7.Other Drugs  8.Other

List Allergy #'s. Describe reaction and treatment \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## Section 5 – Immunizations

Camper must be immunized according to DHEC standards. Are immunizations required for public school up to date?  Yes  No

## Section 6 – Health History

**Please know that we value your privacy. Health History information is available only to the camp health care staff. Only after a conversation with you and with your permission will any of this information be given to your child's counselor. We request this information in order to give your child and all the other children at camp a more successful and safe experience. The more information you provide, the better we can do our job. Thanks!**

Has the camper had a history of or is prone to any of the following (Please check all that apply):

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> 1.Recent injury, illness, or infectious disease | <input type="checkbox"/> 12.Heart Defect/Disease              | <input type="checkbox"/> 23.Diarrhea or Constipation          |
| <input type="checkbox"/> 2.Chronic or recurring illness                  | <input type="checkbox"/> 13.Hypertension                      | <input type="checkbox"/> 24.Frequent Stomachaches             |
| <input type="checkbox"/> 3.Asthma  | <input type="checkbox"/> 14.Bleeding/Clotting Disorders       | <input type="checkbox"/> 25.Needs to wear glasses or contacts |
| <input type="checkbox"/> 4.Homesickness                                  | <input type="checkbox"/> 15.Diabetes                          | <input type="checkbox"/> 26.Been hospitalized recently        |
| <input type="checkbox"/> 5.History of Bedwetting                         | <input type="checkbox"/> 16.Mononucleosis (in last 12 months) | <input type="checkbox"/> 27.Wears a Medic Alert ID            |
| <input type="checkbox"/> 6.Sleepwalks                                    | <input type="checkbox"/> 17.Joint Problems (knees, ankles)    | <input type="checkbox"/> 27.Other _____                       |
| <input type="checkbox"/> 7.Nightmares/Night Terrors                      | <input type="checkbox"/> 18.Fractures (2 months)              |   |
| <input type="checkbox"/> 8.Frequent Ear Infections                       | <input type="checkbox"/> 19.Frequent Headaches or Migraines   |   |
| <input type="checkbox"/> 9.Seizure Disorder or Convulsions               | <input type="checkbox"/> 20.Head Injury                       |   |
| <input type="checkbox"/> 10.H.I.V  | <input type="checkbox"/> 21.Psychiatric Disorder or Treatment |   |
| <input type="checkbox"/> 11.Hepatitis                                    | <input type="checkbox"/> 22.Eating Disorder                   |   |

Please list the number and provide explanation for any checked items

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## Section 7 – Authorization

Regarding my child \_\_\_\_\_, the information provided on this form is accurate to the best of my knowledge. I have indicated any special health conditions, including required medication and activity limitations which should be known to the camp staff and medical personnel. In addition, by signing below, I authorize Bethel, after an attempt to contact me in a timely manner, to act in place of parents/guardians to secure proper medical treatment, hospitalizations, injections, medicines, transfusions, and/or surgery in the event of an emergency. I also agree for the camper to be given the medicines listed in section three in the manner they are prescribed and/or directed.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE RETURN HEALTH FORM  
BEFORE YOU COME TO CAMP**

Mail Completed Form To: Bethel Christian Camp  
750 Boy Scout Rd  
Gaston, SC 29053

OFFICE USE ONLY	
DATES	
EVENT	
CABIN	
COUNSELOR	