# HEALTH FORM

CROSS ROADS CAMP & RETREAT CENTER

29 PLEASANT GROVE RD.
PORT MURRAY, NJ 07865
908.832.7264

Camper Name: ______________________________ Birth Date: ___/___/_____
Program Name: ______________________________ Age: ______
Camper Address: ______________________________ Sex: ☐ Male ☐ Female
______________________________
Home Phone: (____)________________________

Parent/Guardian: ________________________________ Home Phone: (_____)________________________
Address: ________________________________ Work Phone: (_____)________________________
Name of Health Insurance*: ________________________ Group/Policy #: ________________________
Name of Parent Carrying Health Insurance: ________________________ Parent SS#: ________________
***Please include a copy of the front and back of your insurance card***

If not available in an emergency, notify:
Name: ________________________________ Phone: (_____)________________________
Name: ________________________________ Phone: (_____)________________________
Name of Physician: ________________________ Phone: (_____)________________________

## HEALTH HISTORY

*To be completed by Parent/Guardian*

Chronic Problems:
- ☐ Ear infections
- ☐ Asthma
- ☐ Diabetes
- ☐ Headaches
- ☐ Bedwetting
- ☐ Sleepwalking
- ☐ Learning Disability
- ☐ Psychiatric Care
- ☐ Seizures
- ☐ Other: ____________

Allergies:
- ☐ Food
- ☐ Medication
  - ☐ Penicillin
  - ☐ ____________
- ☐ Insect Stings
- ☐ Hay Fever
- ☐ Other: ____________

Immunization Dates:
(month/year)
- ___/___ DPT series
- ___/___ Mumps
- ___/___ Measles
- ___/___ Rubella
- ___/___ Polio Series
- ___/___ Hepatitis B Series
- ___/___ Tetanus Booster

Describe Management of chronic problems and/or allergies: ________________________
________________________________________________
________________________________________________
________________________________________________

Describe past medical treatments, surgeries, hospitalization, injuries, special restrictions, or considerations while at camp: ________________________________
________________________________________________
________________________________________________

Describe treatment your son/daughter receives for emotional, learning, or psychological concerns: ________________________________________
________________________________________________
________________________________________________

For Female: has this person menstruated? _______ If not, has she been told about it? ________
If so, is her menstrual history normal? _______ Special considerations: ___________________
________________________________________________

Dietary Restrictions: ________________________________________
________________________________________________

| | | |
|---|---|---|
| Is your son/daughter a vegetarian? | ☐ Yes | ☐ No |
| Has your son/daughter had chicken pox? | ☐ Yes | ☐ No |
| Has your son/daughter ever been to camp before? | ☐ Yes | ☐ No |
| Has your son/daughter ever been homesick? | ☐ Yes | ☐ No |
| Does your son/daughter wear glasses/contacts? | ☐ Yes | ☐ No |
| Does your son/daughter have braces? | ☐ Yes | ☐ No |
| Does your son/daughter wear a retainer? | ☐ Yes | ☐ No |

Please use this space to provide any other information about your son/daughter's health: ______
________________________________________________

## PARENT/GUARDIAN AUTHORIZATIONS

### CAMP MEDICATIONS

The following list includes over-the-counter medications which are available to treat minor afflictions as listed below. The dosage is determined according to the size/age of child, and the specific directions listed on the medication. Please indicate whether or not these treatments may be given for each condition listed. **Reminder: The camp will contact you immediately if illness develops, or emergency treatment is required!**

| Yes | No | Medication | Condition |
|---|---|---|---|
| ___ | ___ | Acetaminophen (Tylenol) | Relief of minor headache or fever |
| ___ | ___ | Antifungal foot powder or cream | |
| ___ | ___ | Milk of Magnesia | |
| ___ | ___ | Robitussin and Robitussin DM | |
| ___ | ___ | Sore Throat Lozenges | Sore Throat |
| ___ | ___ | Sudafed | Relieve Congestion, runny nose |
| ___ | ___ | Antihistamine (Benadryl) | relieve allergic reactions |
| ___ | ___ | Tums | |
| ___ | ___ | Antibacterial Soap | Clean abrasions/cuts |
| ___ | ___ | Bacitracin | Treat abrasions/cuts |
| ___ | ___ | Zinc Oxide/Solarcaine | Relief/Treatment minor burns |
| ___ | ___ | Sunscreen | Prevent Sunburn |
| ___ | ___ | Caladryl or Calamine | Poison Ivy |
| ___ | ___ | Hydrocortisone Cream | Poison Ivy |
| ___ | ___ | Imodium | Diarrhea |

**OTHER MEDICATIONS WITH DOSAGE/SCHEDULE** to be taken while at camp: (all medication ***MUST*** be in its original container)

Medication: ______________________________ Dose: __________ Time: __________
Medication: ______________________________ Dose: __________ Time: __________
Medication: ______________________________ Dose: __________ Time: __________

### *PERMISSION TO GIVE MEDICINE:*

I hereby give permission for the camper as previously named to receive the above treatments as indicated with aid from designated Cross Roads staff as selected by the camp director.

Parent's Signature: ______________________________ Date: _____/_____/_________

### *PARENT'S PERMISSION:*

I hereby give permission for my son/daughter to participate in all camp activities including challenge/ropes course, servant event projects, except as previously noted. Further, I give permission for use of photos/videos of my son/daughter to be used in camp promotion unless noted. My son/daughter will follow the rules of the camp and the directions of the camp staff.

Parent's Signature: ______________________________ Date: _____/_____/_________

### *AUTHORIZATION FOR TREATMENT:*

I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests, and necessary transportation for my son/daughter. In the even I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization for my son/daughter as named above.

Parent's Signature: ______________________________ Date: _____/_____/_________

### *CAMPER CHECKOUT:*

When the normal camp session is complete, the following adult(s) will be picking up my son/daughter:

Name: ______________________________ Phone: (_____)____________

***Please call the camp office if this name changes prior to the checkout time. Thank You!***

### *PHYSICIAN'S APPROVAL:*

The camper named above has been examined within the past 12 months (exam date: __/__/___) and found to be in physical condition fit to attend and participate in summer camp activities. Any comments, concerns, restrictions, or advisories are listed in detail with a signature on a separate attached page.

Signature of Licensed Medical Professional:______________________________ Printed: ______________________

Phone: (_____)____________ Address: ______________________________ State: ______ Zip: _________

FOR CAMP USE

Date of Health Screening: ____________ Name of Health Care Administrator: ______________________________