



The information on this form is necessary to assist us in identifying appropriate care. Provide complete information on both sides of this form so that Dwight Mission can be aware of your needs. Forward completed form to Dwight Mission two weeks prior to your camp session. Any changes to this information should be provided to camp health personnel upon participant's arrival at camp.

Participant Information

Participant's Name: _____ Birthdate: _____ Age at Camp: _____
 Social Security Number of Participant: _____ Gender: Male Female
 Address: _____
 City: _____ State: _____ Zip: _____
 Family Physician: _____ Dentist: _____
 Phone: (____) _____ Phone: (____) _____
 Date of most recent examination: _____ Is the participant covered by family medical/hospital insurance? Yes No
 If yes, Insurance Carrier and Policy or Group #: _____
 Name of insured _____ Relationship to participant _____
 Social Security Number of policy holder or insurance ID number _____
(Part of your registration fee has covered the cost of minimal secondary medical insurance for camp.)

Name:

Contact Information

Custodial Parent/Guardian: _____ Relationship to Camper: _____ <small>(i.e. Mother, Father, Step Mother, Grandmother)</small> Day Phone: _____ Night Phone: _____ Cell Phone: _____	Second Parent/Guardian: _____ Relationship to Camper: _____ <small>(i.e. Mother, Father, Step Mother, Grandmother)</small> Day Phone: _____ Night Phone: _____ Cell Phone: _____
Additional Contact: _____ Relationship to Camper: _____ Day Phone: _____ Night Phone: _____ Cell phone: _____	Comments: _____ _____ _____ _____

Allergy Information

Please list all known. Medication Allergies (list)	Describe reaction and management of the reaction.
_____	_____
_____	_____
_____	_____
Food Allergies (list)	
_____	_____
_____	_____
_____	_____
Other Allergies (list)	
_____	_____
_____	_____
_____	_____

Event #:

Event #:

General Questions

Has/does the participant:	Y	N
1. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
3. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>
5. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever been diagnosed with a heart defect/disease?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>
8. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
14. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
15. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
16. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have a bleeding/clotting disorder?	<input type="checkbox"/>	<input type="checkbox"/>
18. Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
20. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
21. Ever had problems with joints (e.g. knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
22. Have any skin problems (e.g. itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
23. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
24. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
25. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
26. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
27. Ever has emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>

If yes to any, please reference number and explain below.

Females	Y	N	If not normal, please describe:
Has she menstruated?	<input type="checkbox"/>	<input type="checkbox"/>	_____
If, no has she been told about menstruation? ...	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes, is her menstrual history normal?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other Information

Please provide any additional information about the participant's behavior and physical, emotional, or mental health about which camp staff should be aware in order to provide the best care.

Pick-Up

Who will pick up the participant from Dwight?

Immunizations

Which of the following has the participant had?

- | | | |
|---|--------------------------------------|--------------------------------|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Hepatitis B | |
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Hepatitis C | |

Please provide all dates of immunization:

Vaccine	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	_____	_____	_____	_____
TD (tetanus/diphtheria)	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____
Polio	_____	_____	_____	_____
MMR	_____	_____	_____	_____
or Measles	_____	_____	_____	_____
or Mumps	_____	_____	_____	_____
or Rubella	_____	_____	_____	_____
Haemophilus influenza B	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____
Varicella (chicken pox)	_____	_____	_____	_____

Restrictions

Dietary Restrictions(please be specific) _____

Activity Restrictions(please be specific) _____

Authorizations

ACCURACY OF INFORMATION: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all activities except as noted.

ADMINISTRATION OF ALL MEDICATION: I understand that all medications (prescription and nonprescription), with full instructions for taking, brought by my child to camp will be turned over to and stored by Dwight Mission staff along with this form. I hereby agree to waive any cause of action against the director, staff, sponsors, or any employee of Dwight Mission for illness, injury, or death of my child arising from his or her failure to take said medication as properly prescribed by his/her physician. I have explained the proper method of taking medication to him/her and he/she understands and agrees to take the medication as prescribed.

EMERGENCY AUTHORIZATION: I hereby give permission to the medical personnel selected by the event director to order X-rays, routine tests and treatment for me/or my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the event director to hospitalize, secure proper treatment for, and order injection and/or anesthesia and/or surgery for me or my child as named above. This completed form may be photocopied for trips away from camp.

COVENANT AGREEMENT: I have discussed appropriate behavior with my child and the importance of following the rules of Dwight Mission. I agree that should my child break any rules established by Dwight Mission and it be deemed necessary by the event director to send my child home early, I will pay the transportation costs.

Participant Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Witness Signature _____ Date _____

Name:



This form must be completed for anyone who brings medication to camp.
 This form and the medication must be turned over to camp staff at registration.

In order to help the check-in process go smoothly, we ask that this form be completed if it is necessary for a participant to bring any medication to camp. We also require that all medication be given to our staff during check-in including aspirin, Tylenol, Advil, nasal spray, etc. Clearly mark the participant's name and instructions on any nonprescription medication. Our infirmary is fully stocked with many over-the-counter medications. **Please do not send prescription medication unless it has been prescribed for the person attending camp and is in the original packaging/bottle that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration.** Thank you for completing this form and having your camper's medication properly marked and stored before arriving at camp.

Participant's Name: _____

Event: _____ **Dates of Event:** _____

Parent's Name and Phone #: _____

Please list all medication taken routinely and brought to camp (including the name, dosage, specific times to be taken each day, amount brought to camp in #'s and reason for taking).

	Medication	Dose	Time	Quantity of medication brought to camp	Reason for taking
1.					
2.					
3.					
4.					
5.					
6.					
7.					

Name:

Event #: