SO PA DISTRICT YOUTH EVENT
HEALTH HISTORY FORM

Date of District Youth Event _____

Name _____ Birth Date _____ Age _____
Last *First* *M.I.*

Home address _____
Street address *City* *State* *Zip*

Gender: ☐ Male ☐ Female

Parent/guardian name _____ Home Phone _____

Home address _____
(if different from above) *Street address* *City* *State* *Zip*

Cell Phone _____ Work Phone _____ Work Hours _____

Emergency contact in the event we are unable to contact the parent: ☐ Emergency Contact or ☐ Second Parent/guardian
(other than listed above)

Name _____ Relationship _____

Address _____
Street address *City* *State* *Zip*

Home Phone _____ Work Phone _____ Cell Phone _____

INSURANCE INFORMATION

Is the Youth covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name _____ Group # _____

Carrier address _____

Name of insured _____ Relationship to Youth _____

Insurance ID number _____

ALLERGIES

Describe reaction and management of the reaction.

Medication allergies (list)

_____ _____

_____ _____

Food allergies (list)

_____ _____

_____ _____

Other allergies (list) – include insect stings, hay fever, asthma, etc.

_____ _____

_____ _____

Please complete information and sign the other side of this page.

Bring this completed form to the event.

You will not be admitted to the event without this completed form.

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter) being taken by the Youth. Bring enough medication to last through the event. Keep it in the original packaging with the prescription information attached (prescribing physician, name of medication, dosage, and administration instructions).

☐ This person does not need medication during the event

OR

☐ This person takes the following medication:

Med #1 _____ Dosage _____ Specific times taken each day_____

Reason for taking_____

Med #2 _____ Dosage _____ Specific times taken each day_____

Reason for taking_____

ATTACH ADDITIONAL PAGES FOR MORE MEDICATIONS.

Food Restrictions:_____

Activity Restrictions:_____

GENERAL QUESTIONS (Explain "yes" answers below)

Has/does the Youth participant:	YES	NO
1. Had any recent injury, illness or infection?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐
3. Have frequent headaches?	☐	☐
4. Wear glasses, contacts, protective eyewear	☐	☐
5. Ever had seizures?	☐	☐
6. Ever had high blood pressure?	☐	☐
7. Ever had problem with joints (knees, ankles)?	☐	☐

	YES	NO
8. Have problems with sleep walking?	☐	☐
9. Have problems with bedwetting?	☐	☐
10. Ever had an eating disorder?	☐	☐
11. Ever had emotional difficulties for which professional help was sought?	☐	☐

Please explain any "yes" answers, noting the number of the question:_____

_____

Please explain any recent illness and dates the camper has had:_____

_____

Approximate Height _____ Approximate Weight _____

Parent/Guardian Authorizations: In signing this agreement, I certify that this health history is correct and complete to the best of my knowledge, and the person described is in good health, except as noted, and may participate in camp activities. As a parent/guardian of this Youth, I agree to be partners with Advisors in the enforcement of District policies. I agree to support the Youth Advisors if disciplinary action is necessary.

I hereby authorize the Advisors and Staff leaders to order treatment, x-rays, and routine tests; to release any records necessary for insurance purposes; and to provide or arrange necessary transportation for medical reasons. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the Youth Advisor to secure and administer treatment, including hospitalization, for the person named above. This form, or a copy of this form, may also be used for trips off of Camp Eder property. In signing this, I release and hold harmless the Southern Pennsylvania District of the Church of the Brethren and Camp Eder staff from any liability, except for that which is a direct result of gross negligence.

Additionally, I understand that District Nurture Commission members and Camp Eder staff will NOT hold or administer prescription medicine during this District Youth Event. I recognize the expectation that either my Youth or their Youth advisor will retain any necessary prescription medication in adherence with our individual church's policy or, in the absence of such policy, my preference.

Signature of parent/guardian _____

Printed name _____Date _____

ADDITIONAL INFORMATION Please provide any additional information about your child you feel we should be aware of medical or otherwise.

_____