

Health History Form/Bus Pass  
Covenant Pines Bible Camp

(To be filled out by Parents/Guardians)

State law requires an immunization record giving dates indicating that the camper is fully protected from the included diseases. A Doctor or Nurse must review and sign this history form within 90 days of the start of the camp session.

Camper First Name \_\_\_\_\_ Camper Last Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  Male  Female  
Home Phone (\_\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Custodial Parents/Guardian First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
Father's Day Phone (\_\_\_\_\_) \_\_\_\_\_  
Mother's Day Phone (\_\_\_\_\_) \_\_\_\_\_  
Father's Cell Phone \_\_\_\_\_  
Mother's Cell Phone \_\_\_\_\_  
Emergency Contact \_\_\_\_\_  
Emergency Contact's Phone (\_\_\_\_\_) \_\_\_\_\_  
Health Insurance Co. \_\_\_\_\_  
Policy Number \_\_\_\_\_  
Policy Holder's Full Name \_\_\_\_\_  
Employer \_\_\_\_\_  
Policy Holder's Birth date \_\_\_\_\_  
Phone (\_\_\_\_\_) \_\_\_\_\_  
Insurance Co. Billing Address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Name of camper's physician \_\_\_\_\_ phone \_\_\_\_\_  
Name of dentist \_\_\_\_\_ phone \_\_\_\_\_  
Name of orthodontist \_\_\_\_\_ phone \_\_\_\_\_

Has camper had instances with the following? If so, give date(s).

Recent Surgery \_\_\_\_\_  Asthma \_\_\_\_\_  
 Convulsions/Seizures \_\_\_\_\_  Fainting \_\_\_\_\_  
 Mental Health \_\_\_\_\_  Diabetes \_\_\_\_\_  
 Heart Trouble \_\_\_\_\_  Kidney \_\_\_\_\_  
 Migraines \_\_\_\_\_  Chronic Illness \_\_\_\_\_

Has camper been immunized against the following? If so, GIVE MOST RECENT DATES (As required by law).

Polio \_\_\_\_\_  Diphtheria, Pertussis, Tetanus \_\_\_\_\_  
 MMR \_\_\_\_\_  Hepatitis B \_\_\_\_\_  
 Chicken Pox \_\_\_\_\_

Has camper been exposed to any significant communicable disease, including tuberculosis? If so, state disease \_\_\_\_\_ Date \_\_\_\_\_

Difficulties: Nosebleeds, Nightmares, Sleepwalking, Bedwetting, Behavioral issues, other precautions \_\_\_\_\_

Campers Name \_\_\_\_\_

This camper is allergic to  Food  Medicine  The environment (i.e. insect sting, seasonal allergies)

**Please Comment:** \_\_\_\_\_

Covenant Pines carries over-the-counter medications in the health center. Please do not feel you need to send these with your child, unless they are needed on a regular basis. **It is required to send all prescription medications and over the counter medications in their ORIGINAL pharmacy container (with name, dose, frequency, clearly written) in order to have our nurse safely administer them.** Campers who have diabetes, asthma, and allergies must bring the appropriate emergency medication (i.e. insulin, glucagon, albuterol inhaler, epi-pens, nebulizer and medication). Campers needing medication for the above conditions will not be admitted to the session until Covenant Pines has received all appropriate medications in their original pharmacy container.

**Medication:**  This camper will not take any daily medications while attending camp.  
 This camper will take the following daily medication(s) or "as needed" medications while at camp: note for programmer - If yes than the following is required

Medication 1: \_\_\_\_\_ Reason for taking: \_\_\_\_\_

When to be taken: \_\_\_\_\_ Amount or dose given: \_\_\_\_\_ How Given \_\_\_\_\_

Medication 2: \_\_\_\_\_ Reason for taking: \_\_\_\_\_

When to be taken: \_\_\_\_\_ Amount or dose given: \_\_\_\_\_ How Given \_\_\_\_\_

Medication 3: \_\_\_\_\_ Reason for taking: \_\_\_\_\_

When to be taken: \_\_\_\_\_ Amount or dose given: \_\_\_\_\_ How Given \_\_\_\_\_

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. **Cross out those the camper should NOT be given.**

Tylenol (various strengths)	Ibuprofen (and children's Motrin)
Sudafed PE	Robitussin DM
Benadryl	Generic cough drops
Chloraseptic Lozenges	Antibiotic cream/Bacitracin
Calamine Lotion	Tums
Hydrocortisone cream/spray	Tinactin/Desenex

IN CASE OF EMERGENCY, IF I CANNOT BE CONTACTED, I HEREBY GIVE PERMISSION TO THE MEDICAL PERSONNEL SELECTED BY THE CAMP DIRECTOR TO SECURE AND ADMINISTER TREATMENT, INCLUDING HOSPITALIZATION, FOR THE PERSON NAMED ABOVE. THE COMPLETED FORMS MAY BE PHOTOCOPIED FOR TRIPS OUT OF CAMP.

\_\_\_\_\_  
**(PARENT SIGNATURE) (DATE) Must Be Signed**

**Information below to be completed by doctor or nurse.**

- I have reviewed and there is no evidence of a health problem or activity limitation.  
 Review indicates physical is necessary and must be done within 90 days of camp attendance.

Signature of reviewing Doctor or Nurse \_\_\_\_\_

Additional Comments of Physician \_\_\_\_\_

**NO CAMPER WILL BE PERMITTED TO BOARD THE BUS FOR CAMP WITHOUT THIS COMPLETE HEALTH HISTORY FORM, SIGNED BY PARENT AND DOCTOR OR NURSE**