MICHIGAN AREA United Methodist CAMPING
www.umcamping.org

Health Form for Adult Campers

The information in this form is to assist us in identifying appropriate care.

Name_____ Age_____ Date of Birth_____

Permanent Address_____

Gender: Male_____ Female_____

Home Phone _____ Cell Phone _____ Email _____

Emergency Contact _____ Relationship _____

Home Phone _____ Cell Phone _____

Allergies: *Check those that apply to you.*

_____ I have no known allergies.

_____ I have an allergy to this/these food/s:_____

Describe what happens if you eat this food and how the reaction is managed: _____

_____

_____ I am allergic to this medication/s:_____

_____ I am allergic to these substances: _____

Describe what happens if you take/come in contact with this and how the reaction is managed:_____

_____

Chronic Concerns: *Check all that pertain to you and provide information about supportive healthcare.*

_____ I have no chronic health concerns

_____ I have the following chronic health concerns:

□ Asthma	□ Headaches/Migraines	□ Sleep Problem
□ Diabetes	□ Difficult Breathing	□ Dysmenorrhea
□ Fainting	□ Surgery History	□ Seizure disorder:_____
□ Back Pain or Injury	□ Knee or Ankle Weakness	□ Other:_____

Provide information about supportive healthcare needed for each checked item: _____

_____

Nutrition: *Our kitchen can work effectively with some medically prescribed diets but does not cater to individual preferences.*

_____ I eat a regular, varied diet.

_____ I am lactose-intolerant. *Be prepared to manage your intolerance using products such as Lactaid or food avoidance.*

_____ I am a vegetarian.

_____ I require a gluten free diet

_____ I respond with an anaphylactic reaction when I eat this food:_____

I am unable to eat the following::_____

_____

_____

Medication: Bring enough medication for your entire stay.

_____ I do not take medication on a routine basis.

_____ I take routine medication (include vitamins) as follows: (attach more information if needed)

Name of medication:_____	Name of medication:_____
Reason for taking:_____	Reason for taking:_____
Dose Taken: _____	Dose Taken: _____
Times: _____	Times: _____

Cont'd. Name of medication:_____ Name of medication:_____
Reason for taking:_____ Reason for taking:_____
Dose Taken: _____ Dose Taken: _____
Times: _____ Times: _____

General Physical History

1. Have you ever been hospitalized? ..... Yes □ No □
   Have you ever had surgery? ..... Yes □ No □
2. Have you ever passed out during or after exercise? ..... Yes □ No □
   Have you ever been told that you have a heart murmur? ..... Yes □ No □
   Have you ever had high blood pressure? ..... Yes □ No □
   Have you ever had racing of your heart or skipped a heartbeat? ..... Yes □ No □
3. Do you have skin problems (itching, rashes, acne)? ..... Yes □ No □
4. Have you ever been knocked out or unconscious? ..... Yes □ No □
   Have you ever had a seizure? ..... Yes □ No □
5. Have you ever had heat or muscle cramps? ..... Yes □ No □
   Have you ever been dizzy or passed out in the heat? ..... Yes □ No □
6. Have you had the chicken pox or are you immunized for chicken pox? ..... Yes □ No □
7. Have you had mononucleosis in the past nine months? ..... Yes □ No □
8. Do you have a hearing problem? ..... Yes □ No □
   Do you have a vision (sight) problem? ..... Yes □ No □
   Do you wear glasses or contacts or use protective eye wear? ..... Yes □ No □
9. Do you typically make noise while sleeping (i.e. snore, talk in sleep, etc.) ? ..... Yes □ No □
10. Do you have any problems with your teeth? ..... Yes □ No □
11. Have you ever sprained, strained, dislocated, fractured, broken or had repeated swelling, or other injuries to any of your body areas? ..... Yes □ No □

    If so, where? □ Head □ Shoulder □ Thigh □ Neck □ Chest
    □ Forearm □ Shin/calf □ Back □ Wrist □ Hand
    □ Ankle □ Elbow □ Knee □ Hip □ Foot

12. Do you smoke and/or use other tobacco products? ..... Yes □ No □
13. Do you have any piercing? ..... Yes □ No □

    If so, where? □ Ears □ Eyebrow □ Nose □ Tongue
    □ Belly Button □ Nipple □ Other: _____

Describe any physical condition requiring restriction(s) on participation in the camp program and a description of that restriction.

_____

_____

_____

Mental and Emotional Health Information

A. Have you been diagnosed with attention deficit (ADD) or AD/HD? ..... Yes □ No □
B. Do you have a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder? ..... Yes □ No □
C. Do you have an eating disorder? Type: _____ ..... Yes □ No □
D. Do you have a learning disability? Type: _____ ..... Yes □ No □
E. Do you have an emotional health concern? ..... Yes □ No □
F. During the past year, have you seen a professional about mental/emotional concerns? ..... Yes □ No □

If yes to any question in this section, attach a statement that:

(a) Describes the concern and your management plan for addressing it while working at camp; and
(b) Describes the support needed from your work supervisor to compliment your plan.

Name of your **physician:**_____ Office Phone:_____
Name of your **dentist/orthodontist**:_____ Office Phone:_____

Signatures Required

- **Authorization** This health form is correct as far as I know and the person herein described has permission to engage in all camp activities except as noted.

- **Permission to Treat:** I hereby give permission to the medical personnel selected by the Camp Director to provide routine health care, to administer medications and to order X-rays, routine tests and treatment for me. I hereby give permission to the medical personnel selected by the Camp Director to hospitalize, secure proper treatment, review my records, discuss my conditions with any medical personnel, and to order injection and anesthesia and/or surgery for me as named above. This form may be photocopied for use out of the camp. This form is a HIPAA authorization release.

- **Transportation Authorization:** I give permission for me to be transported in private vehicle if necessary.

- **Additional Release:** I release all photos, videos and audio tapes of me to MAUMC to be used for promotional purposes.

- I acknowledge that post-camp meetings, reunions, and voluntary events are not conducted under the supervision or auspices/sponsorship of MAUMC, which is not responsible for anyone's well-being at such events.

- **Signature**_____ Date_____

- Printed name: _____

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