Michigan Area United Methodist Camping
2307 W. Maple Rapids Rd.
St. Johns, MI 48879

MICHIGAN AREA United Methodist CAMPING
www.umcamping.org

Phone: 833-588-2267

MAUMC Adult Camper Health Form

For:

Contact Information

Name:

Camper's date of birth mm/dd/yyyy

City

State

ZIP

Street Address

Current Age:

Camper's gender: ○ Male ○ Female

Telephone Number - Home

Telephone Number - Mobile

Allergies

I have no known allergies. ☐

I have an allergy to these foods:

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 this substance(s):

Describe what happens if you take this medication or come into contact with this substance and how the reaction is managed:

I have no chronic health concerns. ☐

I have the following chronic health concerns (check all that apply:)

For:

☐ Asthma	☐ Headaches/Migraines	☐ Surgery History	☐ Dysmenorrhea
☐ Diabetes	☐ Arthritis	☐ Knee or Ankle Weakness	☐ Seizure Disorder
☐ Fainting	☐ Hypertension	☐ Heart Disease	☐ Other
☐ Back Pain or Injury	☐ Difficult Breathing	☐ Sleep Problems	

Provide information about supportive healthcare needed for each checked item. If "other" is checked, please explain.

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

- ☐ I eat a regular and 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:(leave blank if not applicable)

Medications

Medication:
I do not take medication on a routine basis. ☐

I take routine medication (include vitamins) ☐

Name of medication

Reason for taking

Dosage taken

Times

Name of medication

Reason for taking

Dosage taken

Times

Name of medication

Reason for taking

Dosage taken

Times

If additional medications, list Name, Reason, Dose, and Times here.
Please give any additional explanation necessary regarding any of your medications..

For:

General Physical History

Have you ever been hospitalized?	○ Yes	○ No
Have you ever had surgery?	○ Yes	○ No
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 heartbeats?	☐ Yes	☐ No
Do you have skin conditions (itching, rashes, acne?)	○ Yes	○ No
Have you ever been knocked out or unconscious?	○ Yes	○ No
Have you ever had a seizure?	○ Yes	○ No
Have you ever had heat or muscle cramps?	○ Yes	○ No
Have you ever been dizzy or passed out in the heat?	○ Yes	○ No
Have you ever had chicken pox or are you immunized for chicken pox?	○ Yes	○ No
Have you had mononucleosis in the past nine months?	○ Yes	○ No
Do you have a hearing problem?	○ Yes	○ No
Do you have a vision (sight) problem?	○ Yes	○ No
Do you wear glasses or contact lenses or use protective eyewear?	○ Yes	○ No
Do you typically make noise while sleeping (i.e. snore, talk in sleep, etc.?)	○ Yes	○ No
do you have any problems with your teeth?	○ Yes	○ No
Have you ever sprained, strained, dislocated, fractured, broken, or had repeated swelling, or other injuries to any of your body areas?	○ Yes	○ No

For:

If so, where?	☐ Head	☐ Knee
	☐ Forearm	☐ Neck
	☐ Ankle	☐ Wrist
	☐ Shoulder	☐ Hip
	☐ Shin/calf	☐ Chest
	☐ Elbow	☐ Hand
	☐ Thigh	☐ Foot
	☐ Back	
Do you smoke and/or use other tobacco products?	◯ Yes	◯ No
Do you have any piercings?	◯ Yes	◯ No
If so, where?	☐ Ears	☐ Nose
	☐ Belly Button	☐ Tongue
	☐ Eyebrow	☐ Other
	☐ Nipple	
Describe any physical condition requiring restriction(s) on participation in the camp program and a description of that restriction.		

Mental and Emotional Health Information

Have you been diagnosed with Attention Deficit Disorder (ADD) or Attention Deficit with Hyperactivity Disorder(ADHD?)	◯ Yes	◯ No
Do you have a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder, etc.?	◯ Yes	◯ No
Do you have an eating disorder?	◯ Yes	◯ No
Do you have a learning disability?	◯ Yes	◯ No
Do you have an emotional health concern?	◯ Yes	◯ No
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 describes the concern and your management plan for addressing it while at camp; and whether support is needed from camp staff.		

Physician Information

Name of your primary care physician:

For:

Phone number of your primary care physician

Name of your dentist/orthodontist:

Phone Number of your dentist/orthodontist:

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.

Please note any activities excluded for medical reasons.

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 outside of the camp. This form is a HIPAA authorization release.

Transportation Authorization: I give permission for myself to be transported in a private vehicle if necessary.

Additional Release: I release all photos, videos, and audio tapes of myself 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.

Health Insurance Information

Name of primary insurance provider

Insured's ID number

Group number

Insurer's customer service phone number

Signature _____ Date _____