First United Methodist Church, Downers Grove, IL.
Health Form and Permission Form for Senior High Retreat
To Camp Duncan August 16th-17th

Student's Name_____ Birthdate___/___/_____ Age_____ Gender: M or F
Parent/Guardian Name_____ Home Phone_____ Work_____
Address:_____
Cell_____ Grade entering in Fall_____

EMERGENCY CONTACT

Every effort will be made to contact the parent/guardian in the event of an illness or other problem. Please indicate two other persons who know your child, who have authorization for transportation, and who may be contacted in necessary. Contact Information:

Name_____ Relationship_____H:Phone#:_____
Work#:_____
Cell#:_____
Name_____ Relationship_____H:Phone#:_____
Work#:_____
Cell#:_____

ALLERGIES List all known. Describe reaction and management of the reaction.
Does camper have any know allergies? ☐Yes ☐No

Allergies to medications _____
Food allergies_____
Other allergies _____
Dietary restrictions_____

Health History: (Check any that apply)

☐Epilepsy or Seizures	☐Frequent Ear Infections	☐Menstrual Problems	☐Asthma
☐Frequent Sore Throats	☐Headaches	☐Bed-wetting	☐Heart Disease
☐Back pain or strain	☐Alcohol/drug addiction	☐Attention Deficit Disorder	☐Diabetes

☐Other:_____

Pertinent past medical treatment:_____

Is the student presently taking or using any type of medication(s) or drug(s)? ☐Yes ☐No
If yes, specify and complete med report on reverse side.

Is the student current on all immunizations needed for school? ☐Yes ☐No
Date of last Tetanus shot:_____ Blood type (if known) _____

Does the student have a health condition (e.g. allergies, chronic conditions) or special circumstances which may affect program participation, special housing need, or anything we ought to know prior to emergency treatment? ☐Yes ☐No
If yes, please explain:_____

Family Medical Insurance: ☐Yes ☐No Name of Insured_____
Carrier:_____ Group #_____Policy #_____
Name of Family Physician_____Phone_____

Parent/Guardian Authorization

My child has permission to take part in all retreat activities under supervision unless limitations are noted above, and I agree that the retreat personnel will not be held responsible for accidents arising there from. I hereby give permission to the retreat staff to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the retreat staff to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the retreat staff to secure and administer treatment, including hospitalization, injection, surgery and anesthesia for the person named above. This completed health form may be photocopied for trips out of the retreat.

Signature_____ Date_____
(Signature of camper, if age 18 or older, or Parent/Guardian--required each year)

PERMISSION TO ADMINISTER MEDICATIONS

I, the parent or guardian of _____ gives my permission to the retreat Health Care Provider or his/her designate to give the following medications (or generic equivalents) to my child, in accordance with recommended package dosing for the specific indications below. These medications are available at camp and need not be brought by participants.

	Yes	No		Yes	No
Tylenol: mild fever or discomforts	☐	☐	Benadryl: Allergy Symptoms	☐	☐
Ibuprofen: mild fever or discomforts	☐	☐	Sudafed: Allergy symptoms	☐	☐
Throat Lozenges: Cough/sore throat	☐	☐	Antacid: Upset stomach	☐	☐
Topical Creams: Itching, sunburn Or insect bites	☐	☐	Anti-diarrhea: for diarrhea	☐	☐
Permission to follow recommendations by local Poison Control Centers				☐	☐

Signature of Parent/Guardian_____ Date_____

Please describe any current physical, mental, or psychological conditions requiring medication, treatment, or special restrictions or considerations while at the retreat: _____
_____

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. **Bring enough medication to last the entire retreat.** Keep it in the original package-container that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

Med #1_____ Dosage_____ Specific times taken each day_____

Reason for taking_____

Med #2_____Dosage_____Specific times taken each day_____

Reason for taking_____

Med#3_____Dosage_____Specific times taken each day_____

Reason for taking_____

All medications brought to camp MUST be in their original containers.

Note: The retreat personnel will notify you if your child displays the following systems:

- ☐ Any illness that persists longer than 24 hours; including fevers, coughs, excess expulsion of bodily fluids, allergic reactions, severe tiredness.
- ☐ Any injury that causes severe prolonged pain, discolorization and/or swelling
- ☐ Any condition that cannot be sufficiently treated by camp personnel.
- ☐ Any condition requiring transport o other medical services.

Physical and doctor signature no longer required.