CORTLAND BIBLE CAMP HEALTH HISTORY FORM

This form must be completed as a requirement of the NY State Dept of Health for admission to camp

Session_________

Year_______

Name____ Birthdate_____/_____/______ Age:________ Sex: **MALE / FEMALE**
Last First Circle One

Parent or Guardian ____ Phone ______________________

Home Address ____

Emergency Contact__________________________ Relationship______________ Phone ______________________

ALLERGIES

(Please list all known allergies, and describe reaction and management of the reaction)

Medication, Food, or other Allergy	What is the reaction and how is it managed?
Does this camper have any disability or recurring illness?	Does this camper have any dietary modifications?

HEALTH HISTORY

Check all that apply.

___ Frequent Ear Infections
___ Heart Defect/Disease
___ Seizures (Date: __________) Most Recent
___ Diabetes
___ Bleeding or Clotting Disorders
___ Concussion (Date_________) Most Recent
___ Hypertension
___ Psychiatric Treatment

IMMUNIZATION HISTORY

Please record the date (month & year) of basic immunizations and most recent booster doses.

VACCINE	DATE	VACCINE	DATE
DPT		HEP B	
DTP		HEP B	
DTP		HEP B	
POLIO		HIB	
MMR		VARICELLA	
MMR		MENINGOCOCCAL	
TETANUS		OTHER	

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted.

Permission to photo: I hereby give permission to the officials at camp to take still, video, and digital pictures of me/or my child for the use of the camp in promotional publications, print, video, and on the World Wide Web.

Housing: I acknowledge it is BCM International policy is to house camp participants by biological sex.

Authorization for Treatment: I hereby give permission for the camp to provide ongoing and routine healthcare, to administer prescribed medications and seek emergency medical treatment including to order X-rays, routine test, treatment, and necessary transportation for me/or my child. I give permission to the camp to release any records necessary for insurance purposes. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child

Camp staff have permission to assist my child in applying INSECT REPELLANT and SUNSCREEN.
(Cross out if not willing to give permission for either)

Signature ____Date____________________
parent / guardian or Staff

This form should be sent to camp by mail or fax at least 2 weeks ahead of camp. If there is less than 2 week please return it ASAP

Fax (607) 882-6376 or mail to: CBC; P.O. Box 100; Pitcher NY 13136

The following section MUST be completed and SIGNED by Licensed Medical Personnel in order for your camper to receive medication their week of camp.

Name:____ DOB_________________

Standard Over the Counter/PRN Medications: The listed medications are available in the infirmary and will be administered at the discretion of camp medical staff, **only** if the camper's HCP has approved the list above and signed the form above.

Standard Over the Counter / PRN Medications

Medication	Administration Order	Route	Dose	Frequency
Acetaminophen	Yes/No	PO		
Ibuprofen	Yes/No	PO		
Benadryl	Yes/No	PO		
Tums	Yes/No	PO		
Pepto Bismol	Yes/No	PO		

HCP Name:

Phone #:

License #:

Signature:

Date:

Physicians note regarding camper:

Prescription Medications: Please complete the camper's current regimen of scheduled medications including inhalers. All medications sent to camp must be in their original containers. No pill boxes, or unlabeled containers will be accepted. Camp medical staff can only administer scheduled meds if camper's HCP has approved the list and signed the form above.

Medication Name	Dosage	Route	Time/Frequency	Reason for Taking	Side Effects
			____ Breakfast ____ Lunch ____ Dinner ____ Bedtime If PRN: every _____hrs		
			____ Breakfast ____ Lunch ____ Dinner ____ Bedtime If PRN: every _____hrs		
			____ Breakfast ____ Lunch ____ Dinner ____ Bedtime If PRN: every _____hrs		
			____ Breakfast ____ Lunch ____ Dinner ____ Bedtime If PRN: every _____hrs		
			____ Breakfast ____ Lunch ____ Dinner ____ Bedtime If PRN: every _____hrs		