

# CAMPER HEALTH HISTORY FORM

Please complete & return to:

Shepherd's Fold Ranch  
P.O. Box 39  
Avant, OK 74001  
fax (918) 263-2022

Circle Camp: THV RC WC DC Summer Staff

Session Attending: \_\_\_\_\_

Camper Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age at Camp \_\_\_\_\_  
*Last First MI*

Home Address: \_\_\_\_\_  
*City State Zip Code*

Church Membership \_\_\_\_\_ Email Address \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_

Custodial Parent/Guardian \_\_\_\_\_ Primary Phone \_\_\_\_\_  
Place of Employment \_\_\_\_\_ Occupation \_\_\_\_\_  
Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Relationship to Camper: \_\_\_\_\_ Email Address \_\_\_\_\_

Second Parent/Guardian or emergency contact \_\_\_\_\_ Primary Phone \_\_\_\_\_  
Place of Employment \_\_\_\_\_ Occupation \_\_\_\_\_  
Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Relationship to Camper: \_\_\_\_\_ Email Address \_\_\_\_\_

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## Insurance Information

Is the camper covered by family medical/hospital insurance? \_\_\_\_\_ Yes \_\_\_\_\_ No

If so, name of insurance carrier or plan \_\_\_\_\_ Group # \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

SSN of policyholder or insurance ID number \_\_\_\_\_

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## Health History (check if applicable)

- \_\_\_ Asthma
- \_\_\_ Ear Infections
- \_\_\_ Heart Trouble
- \_\_\_ Convulsions
- \_\_\_ Diabetes
- \_\_\_ Measles
- \_\_\_ Chicken Pox
- \_\_\_ Mumps
- \_\_\_ Emotional disorder
- \_\_\_ Bleeding/Clotting disorders
- \_\_\_ ADD/ADHD

## Allergies

- \_\_\_ Insect Stings
- \_\_\_ Penicillin
- \_\_\_ Poison Ivy
- \_\_\_ Hay Fever
- \_\_\_ Foods (please list) \_\_\_\_\_

\_\_\_ Other drugs (please list) \_\_\_\_\_  
Restricted Activities \_\_\_\_\_

Is bed wetting a problem? \_\_\_ Yes \_\_\_ No

Other potential health problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Immunization History: Please list last booster date (month and year required)

DPT (tetanus) \_\_\_\_\_ Polio (OPV) \_\_\_\_\_ MMR \_\_\_\_\_

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### Treatment Facility Information

Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_

Address: \_\_\_\_\_  
City State Zip Code

Name of family dentist/Orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Address: \_\_\_\_\_  
City State Zip Code

### Medications

This Camper takes NO medications on a routine basis.

This Camper takes medications on a routine basis.

Medication #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific time/day \_\_\_\_\_

Reason for Taking \_\_\_\_\_

Medication #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific time/day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Attach additional pages for more medications if necessary.

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### Parental Consent Form

Please read and sign: I hereby attest that I have read and reviewed this form and have completed it accurately and will report any information that may change. I therefore agree that my child/ward may participate in all camp activities including travel off the property. I give my permission for camp medical staff to administer over-the-counter medication under the standing orders of the camp physician, and prescription medications as ordered by a physician. I realize that in the event of an illness or injury while at camp or while participating in its activities, medical treatment may be required. I give my permission for the medical personnel selected by the camp director medical treatment may be required. I give my permission for the medical personnel selected by the camp director to order any medical procedures, including x-rays, routine tests, treatment, hospitalization, and transportation. Furthermore, I agree to bear the cost of all such treatment. I also agree to hold harmless Shepherd's Fold Ranch, it's staff, and board of directors from any and all liabilities, claims, demands, and causes of action whatsoever which may arise due to the participation of myself or my child/ward in said activities.

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Signature of Parent or Guardian (over age 18)

Date