

# HEALTH QUESTIONNAIRE FOR BEREAN BIBLE CHURCH CAMP

Camper Name: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

Phone:(    ) \_\_\_\_\_ Work/Cell Phone:(    ) \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone:(    ) \_\_\_\_\_

Address: \_\_\_\_\_

**Health History:** (Check with approximate dates)

\_\_\_\_\_ Ear Infections  
\_\_\_\_\_ Sleepwalking  
\_\_\_\_\_ Last Tetanus

\_\_\_\_\_ Convulsions  
\_\_\_\_\_ Ivy Poisoning  
\_\_\_\_\_ Insect Bites  
\_\_\_\_\_ Bed Wetting

**Allergies:**

\_\_\_\_\_ Drug  
\_\_\_\_\_ Environmental  
\_\_\_\_\_ Food  
\_\_\_\_\_ Other

**Diseases:**

\_\_\_\_\_ Chicken Pox  
\_\_\_\_\_ Asthma  
\_\_\_\_\_ Diabetes

Please list anything about your child's psychological or emotional health that will pertain to his/her welfare or activity at camp.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(PARENT MUST SIGN AUTHORIZATION FORM BELOW)** *Before signing, please complete Health History above*

*This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities above, except as noted by me. In the event I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by the camp director, to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child as named above.*

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**NO MEDICATIONS** will be given unless sent by parent/guardian. EACH medication is to be accompanied by a signed Medication Permission Form which must be obtained prior to camp. *Note: This includes over-the-counter medications such as Tylenol, aspirin, etc.*

# MEDICATION PERMISSION FOR BEREAN BIBLE CHURCH CAMP

(This form must be turned into Camp Nurse with all medication at time of Registration) This will serve as an official request for designated camp personnel to dispense medication to my child during his/her time at camp.

Name of Camper: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Date: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_

## **NON-PRESCRIPTION MEDICATION:** (Bring in Original Container)

Name of Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Specific Instructions and Time for Administration: \_\_\_\_\_

Date to be started: \_\_\_\_\_ Discontinue after: \_\_\_\_\_

## **PRESCRIPTION MEDICATION:** (Bring in Original Prescription Container)

Physician's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

### **Physician's Direction** (This must be completed by your physician)

Prescription and Instructions: \_\_\_\_\_

Please observe the following: \_\_\_\_\_

Pertinent information that will help us better serve your patient: \_\_\_\_\_

Date to be started: \_\_\_\_\_ Discontinue after: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_