Colorado Christian Youth Camp **Camper Health History Record**

Please return form to: Colorado Christian Youth Camp, 2893 Patterson Road, Grand Junction, CO 81506
Please print and complete the form manually, please print clearly.

Camper Name: _____ Birthdate (month/ date/ year): _____ Gender: _____

Address (street address, city/state, zip): _____

Cell phone: _____ Daytime phone: _____ Evening Phone: _____

Parent/Legal Guardian (if camper under 18): _____ Phone: _____

Medical and Insurance Information:

Name of Family PHYSICIAN/Clinic: _____ Phone: _____

Name of Family DENTIST: _____ Phone: _____

Name of Insurance Carrier: _____ Policy#: _____

Insured's Name: _____ Member ID#: _____

Insured's Employer (if insurance is through work): _____ Phone: _____

Others who could be contacted to authorize medical treatment:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

PART A: Allergies	**Check those that apply.** Specify cause and nature of reaction (*i.e., Penicillin causes hives*)		
	☐ Animals:	☐ Insect Stings:	☐ Plants/Trees:
	☐ Hay fever:	☐ Pollen:	☐ Poison Oak:
	☐ Food:		
	☐ Medicine / Drugs:		
	☐ OTHER:		
	In case of an allergic reaction, respond by:		
PART B: Medical History	**Check those that apply**		
	☐ ADD / ADHD	☐ Ear Infection	☐ Mumps
	☐ Arthritis	☐ Eating Disorders	☐ Muscle Disease / Disorder
	☐ Asthma	☐ Emotional Disturbances	☐ Nervous System Disorder
	☐ Anxiety	☐ Epilepsy	☐ Nosebleeds
	☐ Athlete's Foot	☐ Eyes: Contact Lenses	☐ Orthodontic/Dental Appliances
	☐ Behavioral Changes	☐ Eyes: Glasses	☐ Physical Disabilities
	☐ Bed Wetting	☐ Fainting	☐ Runny Nose
	☐ Bipolar Disorder	☐ German Measles	☐ Seizures
	☐ Bleeding / Clotting Disorder	☐ Hay fever	☐ Sickle Cell Trait or Disease
	☐ Bronchitis	☐ Headaches, frequent	☐ Sinusitis
	☐ Chicken Pox	☐ Hearing Impairment	☐ Skeletal Disease / Disorder
	☐ Concussion	☐ Heart Defect / Disease	☐ Skin Conditions
	☐ Constipation	☐ Hepatitis A / B / C	☐ Sleep Disturbance
	☐ Convulsions	☐ Hypertension	☐ Sleep Walking
	☐ Cough	☐ Kidney Disease	☐ Sore Throat
	☐ COVID-19	☐ Measles	☐ Special Dietary Regiment
	☐ Depression	☐ Menstrual Complications	☐ Stomach Upsets
	☐ Diabetes	☐ Migraines	☐ Urinary Tract Infection
	☐ Diarrhea	☐ Mononucleosis	☐ Visual Impairments
	☐ Down's Syndrome	☐ Motion Sickness	
	☐ OTHER:		

PLEASE EXPLAIN:
• Indicate any information useful to the camp health provider in relation to any of the health conditions chosen in PART B.
• Indicate any activity to be encouraged or restricted.

_____
_____
_____

Dietary Needs / Restrictions (a separate form signed by your medical provider is required for food allergies):

_____
_____
_____

Prescribed Medications and Over-the-counter medications: A Permission for Medication Administration form must be completed by your healthcare provider for ALL medications (over-the-counter or prescription, vitamins, and topical treatments).

MEDICATIONS	Listed are all prescribed medication(s) that I will routinely take. Attach a separate list if necessary.		
	Medication	**Dosage**	**How Often?**
Please initial below, if applicable:	Enter name of camper: _____ will self administer the following medications:		
*	Bronchial Inhaler		
*	Epi-pen		
*	Other:		

*The appropriate self-carry form for these medications will be provided if applicable.

Over-the-Counter Medication(s):

Over-the-counter medications will be used to treat routine illness per treatment protocols and standing orders with our physician partner.

I can have: ____ Pain medications ____ Cough syrup ____ Antibiotic ointment ____ Fever reducer ____ Digestive relief

OTHER: _____

I CANNOT have: _____

Health Information Privacy Statement:
The Staff Health Form is for health care concerns during camp. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor of the camp. Minimal necessary information may be shared with camp staff/volunteer(s) in order to provide adequate participant safety and health care. The health history record will be retained by Colorado Christian Youth Camp until it is destroyed. All forms/records with noted treatment will be retained for seven years past the age of maturity of the camper. Access to the information will be limited, but copies may be requested from the camp, by the camper or their legal representative.

Transportation Release:
I authorize transportation for myself or my child (if staff under-18) by emergency vehicle to an appropriate health care facility and pre-hospital medical care, all hospital and physician services, whether medical, surgical and/or dental, necessary for the benefit/safety/well-being of myself or my child (if under-18). It is my expressed intention to hold Colorado Christian Youth Camp harmless for any and all injuries, death or damages arising from or any way related to any such transportation.

Consent to Treat:
I hereby give permission to the physician selected [by the camp nurse / first aider] to order x-rays, routine tests, and treatment for the for the health of myself or my child (if under-18), in the event I cannot be reached in an emergency. I hereby give permission to the physician selected by the camp nurse/first aider to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for myself (if I am unable to do so) or my child (if under-18) named above. For campers under-18, it is understood that every attempt will be made to contact me, or the emergency contact person listed on this form, before taking this action. If it is not possible to locate emergency contacts listed, treatment will not be delayed. I/we will accept the expense of any emergency transportation, medical treatment, or surgical treatment.

The information disclosed on this form may be released to Volunteer/Staff responsible for this activity including, but not limited to Camp Staff, drivers, medical personnel, etc.

Participant Authorization (if over 18):
To the best of my knowledge this health history is correct. I am able to engage in all planned camp activities except as noted. I have read the above procedures for handling the health history form information and I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

_____

Signature of Participant **Date**

_____

Print Name of Participant **Phone** **Email Address**

Parent's / Legal Guardian Authorization (if under 18):
This health history is correct so far as I know, and the person herein described has permission to engage in all planned camp activities except as noted by the examining physician or me. I have read the above procedures for handling the health history form information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

_____

Signature of Parent/Legal Guardian **Relationship to Camper** **Date**

_____

Print Name of Parent/Legal Guardian **Phone** **Email Address**

Last Revised: April 2025