



# CAMPER HEALTH FORM

Return **by May 23** to Iowa Yearly Meeting of Friends, PO Box 657, Oskaloosa, IA 52577  
Please make checks payable to: IAYM Youth Ministries

Camper Name: \_\_\_\_\_ Date of Birth (mm/dd/yy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender: \_\_\_\_\_

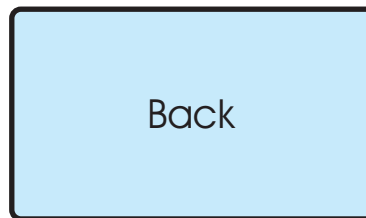
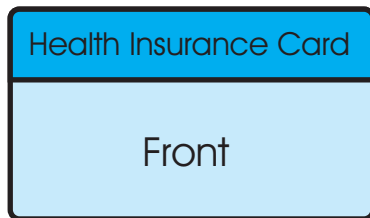
Parent 1 Name: \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Business Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_

E-mail Address: \_\_\_\_\_

(Will be used to confirm the receipt of the registration form)



**HEALTH INSURANCE CARD: You must submit a photocopy of both the FRONT and BACK of your insurance card and prescription card with this form.**

## HEALTH HISTORY (Check – giving approximate dates)

Allergies	Illnesses	Other	Food Allergies
Hay Fever _____	Asthma _____	Migraines _____	List & describe reactions
Ivy Poisonings, etc. _____	Ear Infections _____	Heart Defect _____	_____
Insect Stings _____	Rheumatic Fever _____	Convulsions _____	_____
Penicillin _____	Convulsions _____	Behavior _____	_____
Other Drugs _____	Diabetes _____		_____
	Chicken Pox _____		
	Mononucleosis _____		

Operations or Serious Injuries (Dates) \_\_\_\_\_

Chronic or Recurring Illness \_\_\_\_\_

Other Diseases or Details of Above \_\_\_\_\_

### PARENT SIGNATURE REQUIRED

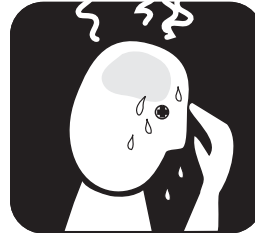
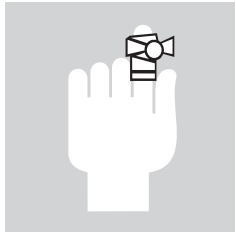
This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted. I hereby give permission to the IAYM Youth Ministries to provide routine health care, administer prescribed medications and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the IAYM Youth Ministries to arrange necessary related transportation. In the event that I cannot be reached in an emergency, I hereby give permission to the physician/health care provider selected by the IAYM Youth Ministries to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

I understand that the IAYM Youth Ministries is not defined as an entity subject to HIPAA and therefore is not covered by HIPAA regulations concerning patient medical records. I also understand and agree that situations may necessitate that my child's medical information be shared with the administrative staff, unit heads, assistant unit heads and counselors, IAYM Youth Ministries doctors and nurses, and the faculty. I give permission to the health care provider, such as a hospital or physician, to share my child's medical information with the IAYM Youth Ministries doctors and nurses and other IAYM Youth Ministries medical staff, for treatment purposes.

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

## IMMUNIZATION HISTORY

DPT Series \_\_\_\_\_ Booster \_\_\_\_\_ Tetanus Booster \_\_\_\_\_  
 Polio OPV (Sabin) / IPV \_\_\_\_\_ Booster \_\_\_\_\_ Hepatitis A \_\_\_\_\_  
 Measles Vaccine (live) \_\_\_\_\_ Hepatitis B \_\_\_\_\_  
 German Measles (Rubella) \_\_\_\_\_ Tuberculin Test \_\_\_\_\_  
 Mumps \_\_\_\_\_ Hemophilus Influenza B (HIB) \_\_\_\_\_  
 MMR \_\_\_\_\_ Other (varicella) \_\_\_\_\_



## Other Info

Has this person ever passed out or been dizzy during or after exercise?  Yes  No

### Recommendations and restrictions while at camp:

Special diet: \_\_\_\_\_  
 Restricted Activities: Swimming: \_\_\_\_\_ Strenuous activity: \_\_\_\_\_  
 Other: \_\_\_\_\_

Provide additional confidential information of which the camp staff should be aware (attach sheet if necessary):

## MEDICATION

Please list all medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person takes **NO** medications on a routine basis.

This person takes medications as follows:

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 \_\_\_\_\_

Attach additional pages for more medications or information about side effects.

Medications taken during the school year that camper does/may not take during the summer: \_\_\_\_\_



## Bunk Mate Request

Part of the camp experience is meeting and building community with new people. Therefore IAYM Youth Ministries guarantees only one bunk mate. **Both campers must have each other's name on registration for this guarantee. No more than two campers from the same church will be in a cabin.**

Name of Bulk Mate: \_\_\_\_\_