



Summer Camping Program HEALTH HISTORY FORM

FOR INFORMATION CONTACT:
Michael Flowers, Men's Ministries
Georgia Baptist Convention
6405 Sugarloaf Parkway
Duluth, Georgia 30097-4092
770.936.5256

This side to be filled in by parents/guardian of minors or by adult participants themselves.

Name _____ Birthdate _____ Sex _____ Age _____
Parent or Guardian _____ Cell/Pager _____
Home Address _____ Phone _____
Business Address _____ Phone _____
Second Parent and/or Guardian or Emergency Contact _____
Home Address _____ Phone _____
Business Address _____ Phone _____
If not available in an emergency, notify _____ Phone _____
Address _____ Phone _____

Health History (check approximate dates)

Diseases
Chicken Pox _____ Measles _____ German Measles _____ Mumps _____

Are you allergic to any
Drugs _____ Foods _____ Insect Bites _____ Other _____

Present medical problems or tendencies (check where applicable)

Has this participant had a DPT shot? _____ Date last tetanus shot _____

Has this participant ever required any psychiatric counseling or hospitalization? _____

List all operations or serious injuries (dates) _____

List all disabilities, chronic and recurring illnesses _____

Sinusitis _____ Diabetes _____ Frequent Colds _____ Heart Trouble _____
Convulsions _____ Fainting _____ Kidney Trouble _____ Frequent Sore Throat _____
Sensitive Skin _____ Sleep Walking _____ Contact Lenses _____ Epilepsy _____
Bronchitis _____ Stomach upset _____ Ear Infections _____ Bed Wetting _____
Other _____

List all dietary limitations _____

List all other diseases or illnesses not listed above _____

Name of dentist/orthodontist _____ Phone _____

Name of family physician _____ Phone _____

Date of last physical examination _____

Suggestions or health related information for camp personnel _____

There has been no changes in my health or physical abilities in the last year _____ yes _____ no

Please explain _____

IMPORTANT - THIS BOX MUST BE COMPLETED FOR ATTENDANCE

This health history is complete and correct, and the person listed below has permission to engage in all prescribed activities except as noted. I hereby give permission to the program staff:

1. To provide ongoing health care.
2. To select medical personnel and to order x-rays or routine tests or treatment for the person listed below.

To my knowledge this participant has not been exposed to a contagious or infectious disease within two weeks prior to this activity. In the event of a medical emergency and I cannot be contacted, I hereby give permission to the Camp Coordinator to select a physician and/or hospital for my child's care. I hereby also give the hospital and/or physician, as selected by the Camp Coordinator, my permission to hospitalize, treat and to order, injections, anesthesia medical treatment and/or surgery for my child whose name is:

Signature _____

Witness _____

Date _____

Notary _____

Relationship _____

Date _____

List medications to be taken, dosage and/or frequency of use: _____

Do you have medical/hospital insurance? _____

Name of Insurer _____

Group or policy # _____

CAMPER INFORMATION

Name _____ Age at Camp _____ Birth Date _____

Parent(s) _____ Vocation _____

_____ Vocation _____

Address _____ City _____ Zip _____

Brothers or sisters (names and ages) _____

Church _____ Association _____ Pastor _____

School _____ Grade _____

Organization Memberships _____

Hobbies _____

Talents _____

Are you a member of an RA Chapter? _____ Challenger? _____ Have you made a profession of faith in Jesus Christ? _____

Have you been to a camp before? _____ If so, where? _____ Do you swim? _____

What do you hope attending Camp Kaleo will do for you? _____

What meaningful experiences do you hope your child will gain from attending Camp Kaleo? _____
