**Camp Rock Ministries Health Form**

This form is required of all participants.

Name of Participant\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian #1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian #1 Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian #2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian #2 Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact #1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact #1 Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact #2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact #2 Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Dietary Restrictions or Allergies?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What over the counter medications is your child able to receive from the camp if necessary? Circle all that apply:

Acetaminophen (Tylenol) Aloe Antibiotic Ointment (Bacitracin, Neosporin)

Bismuth Subsalicylate (Pepto-Bismal, Kaopectate) Calamine Lotion

Calcium Carbonate (Tums, Rolaids) Diphenhydramine (Benedryl) Hydrocortisone 1%

Ibuprofin (Advil, Motrin)

Any health history that we should be aware of:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is the participant covered by family medical/hospital insurance? Yes No

Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing my name and today's date, I am agreeing to the authorization of this health form.Bottom of Form

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_