Health History Form

Florida Annual Conference of the United Methodist Church

Please fill this form out completely and sign it
We recommend that you consult with your family physician when completing this form as necessary.

Retreat Registered For: Annual Conference Youth Caucus 2022

Participant Information:

Participant's Name: _____ Birth date: _____/ _____/ _____

Church Group: _____ Cell Phone: _____

Email Address: _____

Social Security#: _____

Gender: ☐ Male ☐ Female ☐ Non binary Grade in Fall 2022: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Parent/Guardian Name(s): _____

Home Phone: (__) _____ Work Phone: (__) _____ Cell Phone: (__) _____

Does your cell phone have texting capabilities? _____ Email: _____

Parent/Guardian Name(s): _____

Home Phone: (__) _____ Work Phone: (__) _____ Cell Phone: (__) _____

Does your cell phone have texting capabilities? _____ Email: _____

If parent is not available in an emergency, notify: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) Work Phone: ( ) Cell Phone: ( )

Is the participant covered by Family Medical Insurance or Medicaid: ☐ Yes☐ No
Insurance Company: _____ Policy # _____
Group/ID # _____ Name of Policy Holder: _____
Name of Primary Care Provider: _____ Phone: (__) _____
Name of Dentist: _____ Phone: (__) _____
Name of Orthodontist: _____ Phone: (__) _____

List any dietary restrictions: _____

☐ I have reviewed the programs and activities of the event and feel that the participant named above can participate without restrictions.

☐ I have reviewed the programs and activities of the event and feel that the participant named above can participate with the following restrictions or limitations:

_____

_____

Does the participant have a life threatening allergic reaction?
To medications: _____
To foods: _____
To other: _____

Does the participant have a known sensitivity
To seasonal flora, mold, etc.: _____
To food: _____
To other: _____

Health History: (check any that apply)

☐ Ever been hospitalized ☐ Ever had surgery ☐ Recurrent/chronic illness ☐ Recent infectious disease

☐ Recent injury ☐ Has seizures ☐ Fainting or Dizziness ☐ Frequent sore throats

☐ Heart Disease ☐ Had headaches ☐ Back or joint problems ☐ Skin problems

☐ Frequent ear infections ☐ Bedwetting ☐ Had "mono" in the past 12 months

☐ Problems falling asleep/sleepwalking ☐ Wears glasses/contacts ☐ Problems with diarrhea/constipation

☐ Diabetes ☐ ADHD/ADD ☐ Problems with menstruation

☐ Traveled outside of the country in the past 9 months ☐ Asthma/wheezing/shortness of breath

☐ Ever been treated for emotional or behavioral difficulties ☐ Passed out/had chest pain while exercising

☐ Ever been treated for an eating disorder

☐ During the past 12 months seen a professional to address mental/emotional health concerns

☐ Had a significant life event that continues to affect the camper's life (abuse) death of a loved one, divorce, adoption, new sibling, survived a disaster). If yes, please explain _____

_____

☐ Other: _____

Does the participant have a health condition (e.g. allergies, chronic conditions) or special circumstances which may affect program participation, special housing need, or anything we ought to know prior to emergency treatment?□ Yes□ No

If yes, please explain: _____

_____

_____

Please describe any current physical, mental, or psychological conditions requiring medication, treatment, or special restrictions or considerations while involved in this event: _____

_____

_____

Pertinent past medical treatment: _____

Is the participant current on all immunizations needed for school? ☐ Yes ☐ No

If your participant has not been fully immunized, please sign the following statement: ***I understand and accept the risks to my child from not being fully immunized*** _____

Permission to Administer Medications:

I, the parent/guardian of _____give my permission to the Adult in charge or his/her designate to give the following medications (or the generic equivalents) to my child, in accordance with the recommended package dosing for the specific indications below. These medications are available at the event and need not be brought by participants.

	Yes	No
Acetaminophen (Tylenol): fever or discomforts	□	□
Antacid: Upset Stomach	□	□
Anti-gas (Gas-X): Bloating/Gas	□	□
Antihistamine (Benadryl, Zyrtec): Allergy/Cold symptoms	□	□
Decongestant (Phenylephrine HCI): Allergy/Cold symptoms	□	□
Ibuprofen (Advil): Fever or discomforts	□	□
Throat Lozenges (Hall's): Coughs/sore throat	□	□
Topical Creams (Aloe, Benadryl, Hydrocortisone, Neosporin): sunburn, insect bites, minor cuts	□	□
Permission to follow recommendations By local Poison Control Centers	□	□

Signature of Parent/Guardian _____ Date: _____

Parent/Guardian Authorization:

My child has permission to take part in all camp/retreat activities under supervision unless limitations are noted above, and I agree that the camp, conference, or camp or conference personnel will not be held responsible for accidents arising there from. I hereby give my permission to the camp 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 treatment, referral, billing, or insurance purposes. I give permission to the adult in charge to arrange necessary related transportation for my child. In the event that I cannot be reached in an emergency, I hereby give my permission to the physician selected by the camp or retreat to secure and administer treatment, including hospitalization, injection, surgery, and anesthesia for the person named above. This completed health form may be photocopied for trips out of camp or on retreat and/or entered electronically into CampDoc, our confidential on-line Health Management System by Warren Willis Camp staff.

Signature of Parent/Guardian: _____Date: _____

Note: The event personnel will notify you if your child displays the following symptoms:

- Any illness that persists longer than 24 hours; including fevers, coughs, excess expulsion of bodily fluids, allergic reactions, severe tiredness.
- Any injury that causes severe prolonged pain, discoloration and/or swelling.
- Any condition that cannot be sufficiently treated by event personnel.
- Any condition requiring transport to other medical services.