

2027 BLACK ROCK CAMPER & VOLUNTEER HEALTH HISTORY FORM

CAMPER INFORMATION (ALL IS REQUIRED)

Last Name: _____ First Name: _____ MI: _____ Birthday: ____/____/____ Age: _____ Sex: _____
Address: _____ City: _____ State: _____ Zip: _____

PARENT & GUARDIAN INFORMATION (ALL IS REQUIRED)

1st Parent/Guardian: _____
Address (If Different): _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
2nd Parent/Guardian: _____
Address (If Different): _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
If not available in an emergency, notify:
Full Name: _____ Relationship to Camper: _____
Home Phone: _____ Cell Phone: _____

CONDITIONS & DISEASES

ALLERGIES

IMMUNIZATIONS

☐ Asthma	☐ Ear Problems	<div>Mild Moderate Severe</div> <div>Animals.....</div> <div>Insect Stings.....</div> <div>Medication.....</div> <div>Other.....</div> <div>Food Allergies: (<i>serious allergies/ dietary needs should be communicated with pjohnson@brr.org</i>)</div>	Are all immunizations up to date? ☐ Yes ☐ No Please list any immunizations that are NOT up to date: _____ Date of last Tetanus vaccine: ____/____/____
☐ Heart Problems	☐ Stomach Upsets		
☐ Seizures	☐ Bowel Disease		
☐ Diabetes	☐ Bleeding/Clotting		
☐ Psychiatric Treatment	☐ Night Terrors		
☐ Anxiety/Panic Attacks	☐ Sleep Walking		
☐ Depression	☐ Bed Wetting		
☐ Recent Head Lice	☐ ADD/ADHD		
☐ Sinus/Throat Problems	☐ Other (Specify):		

ADDITIONAL MEDICAL INFORMATION

Operations or serious injuries (with dates) _____
Disability or chronic or recurring illness _____
Physical, emotional or intellectual disabilities _____
Activities limited by physician _____
Medically necessary dietary modifications _____
Current medication (we will take instructions at registration) _____
Other diseases or details of above _____

HEALTH CARE PROVIDERS & INSURANCE

Name of dentist/orthodontist _____ Phone _____
Name of family physician & practice _____ **Phone** _____
By signing this health form, I certify that the above named camper is healthy enough to be able to participate in camp activities.
Date of last physical examination _____ (*We recommend last physical examination be within 24 months of child attending camp*).
Does camper have health insurance? ☐ Yes ☐ No
Carrier _____ Policy # _____ Group # _____

LEGAL RESTRICTIONS

Is there anyone legally restricted from seeing the camper? ☐ Yes ☐ No
If Yes, Name _____ Relationship to Camper _____

I hereby certify that the health history information provided for the camper named above is correct so far as I know, and the person named herein has my permission to engage in all prescribed camp activities except as noted. Authorization for Treatment: I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. I give permission to Black Rock Retreat Health Care Staff to administer over the counter, non-prescription medications such as Tylenol, Ibuprofen, cough syrup, antacids, etc. as needed. I give permission to the Health Care Manager and staff selected by Black Rock Retreat Personnel to administer prescribed medication as listed on the form, to perform treatment for minor injuries and illnesses, and to perform First Aid or CPR in the event of a more serious injury or illness. In the event I cannot be reached during an emergency, I hereby give permission for personnel selected by Black Rock Retreat to provide emergency care and treatment to the above named camper in the event of injury or illness. I also give permission for Black Rock personnel to secure needed professional medical treatment by a physician, EMS, or Emergency Room hospital staff as needed and to order X-rays, routine tests, treatment, and any necessary related transportation for me/or my child.

Parent or Guardian Signature _____
Witness _____ Date _____ (will be signed by Registrar when received)