For camp office use only: Date _____ RN Signature/Initials _____

CampSession/year_____Counselor_____Cabin _____

HEALTH HISTORY and MEDICAL INFORMATION

(To be completed and signed by parental guardian; please print legibly in ink.)

Complete health form online or mail paper version to camp at least 2 weeks prior to arrival.

Camp Session and Date Camper is Attending _____

GENERAL INFORMATION

Camper's first & last names_____Gender_____Birthdate_____Age_____

Parent(s)/guardian(s)_____Home phone_____Cell_____

Mailing address_____City_____State_____Zip code+4_____

Work telephone numbers (if applicable) Mother_____ Father_____

Family physician's name_____

If applicable: Affiliated clinic/town of family physician_____Telephone_____

If a parental guardian is not available in case of emergency, notify:

Name(s)_____Telephone(s)_____

HEALTH HISTORY and MEDICAL INFORMATION (CHECK ALL THAT ARE **PERSISTENT** HEALTH PROBLEMS.)

	ADDADHD		Anorexia/Bulimia		Arthritis		Asthma		Bedwetting
	Behavior Challenges		Bladder/Kidney Problems		Constipation		Convulsions/Seizures Type _____		Depression
	Diabetes		Diarrhea		Ear Infections		Eczema		Fainting Spells
	Hay Fever		Headaches		Heart Trouble		Hepatitis and/or known carrier		Homesickness
	Hypertension		Menstrual Pain		Nervousness		Nosebleeds		Rheumatic Fever
	Sinus Trouble		Sleep Walking		Ulcers				

Any other **CHRONIC** or recurring illnesses or conditions not listed above_____

(Please include any necessary information regarding treatment or management.)

Surgeries or serious injuries and dates_____

ALLERGIES: foods/medications/insects, etc._____

Dietary concerns/restrictions_____

If you listed any allergies or dietary restrictions, please provide details about each item listed _____

_____

_____

_____

MEDICATIONS - All medications will be administered by camp staff except inhalers which will be self-administered by camper. **All prescription medication must be appropriately labeled.** Please **list prescription and over-the-counter medicines** that will be taken while at camp. Please use back of page if additional information is needed.

Medication (1): _____ Medication (2): _____ Medication (3): _____

Dose (1): _____ Dose (2): _____ Dose (3): _____

When (1) AM Lunch Dinner Bedtime When (2) AM Lunch Dinner Bedtime When (3) AM Lunch Dinner Bedtime

Notes: _____ Notes: _____ Notes: _____

_____ _____ _____

Medication (4): _____ Medication (5): _____ Medication (6): _____

Dose (4): _____ Dose (5): _____ Dose (6): _____

When (4) AM Lunch Dinner Bedtime When (5) AM Lunch Dinner Bedtime When (6) AM Lunch Dinner Bedtime

Notes: _____ Notes: _____ Notes: _____

_____ _____ _____

The camp has a supply of non-aspirin pain relievers, cough medicine, decongestants, antacids, and first-aid ointments which will be used as indicated following label instructions, so campers do not need to bring their own. Please state any concerns or give instructions regarding use of over-the-counter medications.

_____

Physical activities to be encouraged or restricted_____

IMMUNIZATIONS Completion of the chart below is mandatory **OR** please attach a copy of the immunization record. Please list month and year of vaccination; do not use "current" or "up-to-date."

Date of last Tetanus Shot _____
Month/Year

Pertussis (Whooping Cough) _____ **OR** ☐ Not Vaccinated
Month/Year

*Please note, the pertussis vaccine may have been given in combination with the tetanus vaccine and would have been called DTaP or Tdap.

MMR _____ _____ **OR** ☐ Not Vaccinated
Month/Year shot #1 Month/Year shot #2

Meningitis (MCV_4) _____ **OR** ☐ Not Vaccinated
Month/Year

Chicken Pox _____ _____ **OR** ☐ Has had Chicken Pox **OR** ☐ Not Vaccinated
Month/Year shot #1 Month/Year shot #2

Hepatitis B (HBV) _____ _____ _____ **OR** ☐ Not Vaccinated
Month/Year shot #1 Month/Year shot #2 Month/Year shot #3

FAMILY MEDICAL/HOSPITAL INSURANCE INFORMATION

Insurance Carrier_____ Name of Insured_____

Group Policy Number_____ Insured's Policy Number_____

Please contact program director Katie Vogel (701-263-4788) at least one week prior to your child's arrival at camp if there are any special challenges or considerations (e.g., diabetes; severe asthma; emotional, behavioral, or social disorder) for which our staff should prepare that will impact your child's camp experience. We want to meet your child's needs as best we can. Camp Metigoshe will take all reasonable efforts to reduce the chance of an allergic reaction, but, even with these efforts, there will still be some food made in the same facility as nuts, peanuts, and other allergens.

PARENTAL GUARDIAN'S SIGNATURE TO THE FOLLOWING IS REQUIRED.

I attest that the health history and medical information are correct to the best of my knowledge. The person herein described has permission to engage in all prescribed camp activities, except as noted by me. I agree that Metigoshe Ministries and/or its personnel will not be held responsible for accidents or personal injury arising therefrom. I give permission for camp staff to provide over-the-counter medications according to label instructions, with any specific concerns regarding this noted on the front of this form.

EMERGENCY AUTHORIZATION: I hereby give permission to the medical personnel selected by the camp director to order X-rays, perform routine tests, and treat my child; and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment, and order injection and/or anesthesia and/or surgery for my child named herein. I give my approval to photocopy this form for use out of camp.

PARENTAL GUARDIAN SIGNATURE_____DATE_____

IF YOU DO NOT COMPLETE THIS INFORMATION ONLINE AND CHOOSE TO SUBMIT A PAPER FORM, PLEASE MAIL TO THE CAMP OFFICE AT LEAST 2 WEEKS PRIOR TO THE BEGINNING OF YOUR CHILD'S CAMP. ADDRESS: METIGOSHE MINISTRIES, 165 LAKE LOOP ROAD, BOTTINEAU, ND 58318

PARENT'S PERMISSION TO RELEASE

(if applicable)

It is the policy of Metigoshe Ministries to not release any minor camper into the custody of anyone other than the camper's legal parent(s) or guardian(s) unless written consent is given by such parent or guardian.

Therefore, ***IF*** your child is to be released to a person(s) who is ***NOT*** his/her legal guardian, please complete the following.

Please release my child_____

(print Camper's Name)

into the custody of _____.

(print Name of Person who is ***not*** the legal parent or guardian)

SIGNATURE OF LEGAL GUARDIAN_____DATE_____