

ADULT HEALTH FORM

The North Central New York Conference of The United Methodist Church
Camps, Conferences & Retreat Ministries

Name: _____ Birth date: _____
Street Address: _____ Phone (day): _____
City, State, Zip: _____ Phone (evening): _____
Program name(s): _____ Dates: _____

Please indicate any allergies in the following areas: (please note reaction and treatment.)

Medication Allergies: _____

Food Allergies: _____

Environmental Allergies: _____

Epi-pens used for any allergic responses? _____

List medications you take routinely: Medication, Dosage, Time(s) of Day (Use additional sheet as necessary)

(1) _____
(2) _____

Emergency Contact _____ Relationship _____
Emergency Contact Phone (day) _____ (evening) _____
Insurance Company _____ Policy number _____

In signing this form I hereby certify that this information is correct. In case of medical emergency I understand that every effort will be made to contact the emergency contact person listed. In the event they cannot be reached, I hereby give permission to the physician and other medical personnel selected by the camp to hospitalize, secure proper treatment for and to order injection, anesthesia, or surgery for myself.

Signature _____ Date _____

Immunization History

Required immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster doses.

Date	Most Recent Booster	Vaccine	Date	Most Recent Booster	Vaccine
_____	_____	DTP	_____	_____	MMR
_____	_____	TD (tetanus/diphtheria)	_____	_____	Haemophilus Influenza B
_____	_____	Tetanus	_____	_____	Hepatitis B
_____	_____	Polio	_____	_____	Varicella Zoster (chicken pox)
_____	_____	PPD			

PLEASE CONTINUE BY FILLING OUT THE BACK SIDE OF THIS FORM.

Indicate **AYES@** or **ANO@** for each question.

If yes, give an approximate date. Give any explanation in the space provided or below.

Has/does the participant:	YES	NO	DATE/EXPLANATION
1. Have a chronic or recurring illness/condition?	_____	_____	_____
2. Have frequent headaches?	_____	_____	_____
3. Ever had seizures?	_____	_____	_____
4. Ever had high blood pressure?	_____	_____	_____
5. Ever had back problems?	_____	_____	_____
6. Ever had a heart attack?	_____	_____	_____
7. Ever had problems with joints, knees, ankles?	_____	_____	_____
8. Have diabetes?	_____	_____	_____
9. Have asthma?	_____	_____	_____

Explanations of **AYES@** answers or other **Health Concerns** for which we should be aware. Please note the number of the questions with explanation(s).

ATTACH HEALTH EXAM RECORD INCLUDING DATE OF EXAM OR HAVE YOUR DOCTOR FILL OUT THIS SECTION OF THE FORM.

Health Care Recommendations by Licensed Medical Personnel: Date of most recent physical: _____

I have examined the above camp participant. In my opinion, the above applicant is able to participate in an active camp program as an adult leader with the following restrictions: None _____

Current or on-going treatment at the time of this report include:

Name of Physician: _____ **Phone:** _____

Address: _____

Street

City

State

Zip

Signature of Licensed Physician: _____ **Date:** _____

PLEASE SEND THIS FORM AHEAD OF YOU TO CAMP!