Harvey Cedars
BIBLE CONFERENCE

Church name: _____Youth Week attending: _____ Jr. High / Sr. High (Circle one)

Camper Name: _____
First Middle Last

☐ Male ☐ Female Birth Date_____ Age at time of Youth Week _____
Month/Day/Year

Camper Home Address: _____
Street Address City State Zip

Parent/Guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship to Camper: _____

Preferred Phones (_____)_____ or (_____)_____ Email: _____

Home Address: _____
(If different from above) Street Address City State Zip

Additional Contact if parent(s) /guardian(s) cannot be reached:

Name: _____ Relationship to Camper: _____

Preferred Phones (_____)_____ or (_____)_____ Email: _____

Allergies: ☐ No Known Allergies ☐This Camper is allergic to: ☐Food ☐Medicine
☐ The environment (insect stings, hay fever, etc.) ☐ Other
Please Describe below what the camper is allergic to and the reaction seen:

Dietary Requests: ☐ Requires gluten-free diet. ☐ Requires dairy-free diet. ☐ Requires vegetarian diet.
All other dietary requests will require supplementary items be brought in for meals. A menu can be requested in advance.

Restrictions: Does the camper have any physical restrictions limiting their participation?
(Please describe below)

Medical Insurance Information:
This camper is covered by family medical/hospital insurance ☐ Yes ☐ No
Include a copy of your insurance card; copy both sides of the card so information is readable.

Insurance Company: _____ Policy Number: _____

Subscriber: _____ DOB: _____ Insurance Company Phone (____) _____

Parent /Guardian Authorization for Health Care

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian: _____ **Date:** _____

Relationship to Camper: _____

If for religious or other reasons you cannot sign this, please provide explanation in writing.

Camper Name:
Last
First
M.I.

Immunization History: Provide the month and year for each immunization. Starred (★) immunizations must be current. Copies of immunization forms from health care providers or state or local governments are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/year	Most Recent Dose Month/year
Diphtheria, Tetanus, Pertussis★ (DTaP) or TdaP)						
Tetanus booster ★ (dT) or (TdaP)						
Mumps, Measles, Rubella ★ (MMR)						
Polio ★ (IPV)						
Haemophilus Influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (Chicken Pox) ☐ Had Chicken Pox Date:						
Meningococcal Meningitis (MCV4)						

Tuberculosis (TB) Test	Date:	☐ Negative	☐ Positive

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

Signature of Custodial Parent/Guardian: _____ **Date:** _____

Relationship to Camper: _____

Medication ☐ This camper will not take any daily medication while attending camp
☐ This camper will take the following daily medication(s) while attending camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins and natural remedies.
New Jersey Law requires medication to be in original pharmacy containers with labels which show the camper's name and how the medication should be given. Please provide enough of each medication to last the entire time the camper will be at camp. New Jersey law also requires all medications to be administered by the Camp Nurse/Health Director and not kept in the camper's accommodations.

Name of Medication	Date Started	Reason for Taking	When it is given	Amount or dose given	How it is given
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other :		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other :		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other :		

The following non-prescription medications may be stocked in the Camp Health Center and are used on an as-needed basis to manage illness and injury. **Please cross out and initial those medications the camper should not be given.**

Acetaminophen (Tylenol) [Please initial _____]
Ibuprofen (Advil, Motrin) [Please initial_____]
Phenylephrine decongestant (Sudafed) [Please initial _____]
Cough Syrup [Please initial _____]
Antihistamine/allergy medicine (Benadryl) [Please initial _____]
Bismuth Subsalicylate for Diarrhea (Pepto-Bismol) [Please initial _____]
Imodium [Please initial _____]
Laxatives for constipation (Ex-Lax) [Please initial_____]

As the parent/guardian of the above camper, I request that the medication described above be administered to my child and release Harvey Cedars Bible Conference and/or the Church Youth Pastor/Leader from liability for any damages my child may suffer as a result of this request.

Signature of Custodial Parent/Guardian: _____ **Date:** _____

General Health History: *Check "Yes" or "No" for each. Explain "Yes" answers below.*

Has/does the camper:

1. Ever been hospitalized?..... ☐ Yes ☐ No
2. Ever had eye surgery?..... ☐ Yes ☐ No
3. Have recurrent/chronic illnesses?..... ☐ Yes ☐ No
4. Had a recent infectious disease?..... ☐ Yes ☐ No
5. Had a recent surgery?..... ☐ Yes ☐ No
6. Had asthma/wheezing/shortness of breath?.. ☐ Yes ☐ No
7. Have diabetes?..... ☐ Yes ☐ No
8. Had seizures?..... ☐ Yes ☐ No
9. Had headaches?..... ☐ Yes ☐ No
10. Wear glasses, contacts, or protective eyewear ☐ Yes ☐ No
11. Had fainting or dizziness?……. ☐ Yes ☐ No
12. Passed out/had chest pain during exercise?… ☐ Yes ☐ No
13. Had mononucleosis ("mono") during the past 12 months?. ☐ Yes ☐ No
14. If female, have problems with periods/menstruation?…… ☐ Yes ☐ No
15. Have problems with falling asleep/sleepwalking?…….. ☐ Yes ☐ No
16. Ever had back/joint problems?..... ☐ Yes ☐ No
17. Have a history of bedwetting?..... ☐ Yes ☐ No
18. Have problems with diarrhea/constipation?..... ☐ Yes ☐ No
19. Have any skin problems?..... ☐ Yes ☐ No
20. Traveled outside the country in the past 9 months?..... ☐ Yes ☐ No
21. Recent operations/accidents (head injuries, fractures etc) ☐ Yes ☐ No

Please explain "Yes" answers in the space below noting the number of the question(s).
For travel outside the country, please name the countries visited and dates of travel.

Mental, Emotional, and Social Health: *Check "Yes" or "No" for each statement*

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?.....☐ Yes ☐ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?.....☐ Yes ☐ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?.....☐ Yes ☐ No
4. Had a significant life event that continues to affect the camper's life?..... ☐ Yes ☐ No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below noting the number of the question(s).
Harvey Cedars Bible Conference may contact you for additional information.

Health Care Providers:

Name of camper's primary doctor(s): _____ Phone: (____)_____

Name of dentist(s): _____ Phone: (____)_____

Name of orthodontist(s):_____ Phone: (____)_____

Please provide in the space below any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. Attach additional information if needed.