



Summer Missionary Health Form

A completed and signed Health Form is required for your participation in camp programs.

Please FULLY and NEATLY complete the front and back of this form. Remember to have your parents sign the authorization if you are under 18. Mail form to :
Victory Valley Camp at 7352 Salem Bible Church Road, Zionsville, PA 18092.

Summer Missionary's Name: _____

Sex: Male or Female Birth date: _____ Age: _____

Address: _____

City, State, Zip: _____

PARENT CONTACT INFORMATION

Father: _____ Mother: _____

Cell #: (____) _____ Cell #: (____) _____

Work #: (____) _____ Work #: (____) _____

Emergency Contacts if parent is unable to be reached:

Name: _____ Name: _____

Relation to camper: _____ Relation to camper: _____

Phone #: (____) _____ Phone #: (____) _____

HEALTH INFORMATION

Allergies:

- No Known Allergies
- To foods (**please list**):
- To medications (**please list**):
- To the environment (insect stings, hay fever, etc. – **please list**):
- Other allergies (**please list**):

Diet/Nutrition:

- Eats a regular diet Gluten Free Vegetarian Other (please describe below)
- Dietary notes we should be aware of:

Restrictions: Based on the programs and activities of camp, are there any medical restrictions to your participation in those programs?

- No Yes (if so, please describe):

Insurance: Are you covered by family medical/hospital insurance?

- No Yes (please provide information below)

Insurance Provider: _____ Phone #: _____

Group #: _____ Policy #: _____

Subscriber's Name: _____ Subscriber's birth date: ___/___/___

Health Care Providers:

Family Doctor: _____ Phone #: (____) _____

Dentist/Ortho.: _____ Phone #: (____) _____

Summer Missionary Name:

Summer Missionary Health Form, continued

Medications:

- No daily medications
- Will take the following medication(s) while at camp (include name, dose, frequency):

Please send all medications in a **current prescription bottle**. *For the safety of all campers, please DO NOT pack medications in luggage as they must be turned into the nurse upon arrival.*

Over-the-Counter Medications:

The following non-prescription medications are commonly stocked in our Health Center and are used on an as needed basis to manage illness and injury while at camp. Please indicate which medications you are **NOT** allowed to have.

- None (all are okay to give)
- Contact parent for ANY over-the-counter medicine
- Tylenol (Acetaminophen) Advil (Ibuprofen) Cough Drops Tums
- Sudafed Robitussin Benadryl Pepto-Bismol

General Medical Questions:

My immunizations are up to date - Yes or No Date of last tetanus: ____/____/____
 Preferred Pharmacy: _____

General Health History: Circle "Yes" or "No" for each statement. Explain "Yes" answers below.

Ever been hospitalized?	Yes	No	Ever had surgery?	Yes	No
Have recurrent/chronic illnesses?	Yes	No	Had a recent infectious disease?	Yes	No
Had a recent injury?	Yes	No	Had asthma/wheezing?	Yes	No
Have diabetes?	Yes	No	Had seizures?	Yes	No
Have problems with diarrhea?	Yes	No	Wear glasses/contacts?	Yes	No
Had fainting or dizziness?	Yes	No	Passed out/had chest pain?	Yes	No
Had mono during the last 12 months?	Yes	No	Ever had back/joint problems?	Yes	No
Have problems with sleepwalking?	Yes	No	Have any skin problems?	Yes	No
Have a history of bedwetting?	Yes	No	Had headaches?	Yes	No
			Traveled outside the country in the past 9 months?	Yes	No

If "Yes" to any of the above, please explain:

Mental Health History: Circle "Yes" or "No" for each statement. Explain "Yes" answers below.

Ever been treated for ADD/ADHD?	Yes	No
Ever been treated for emotional or behavioral difficulties or an eating disorder?	Yes	No
During the past 12 months, seen a professional to address mental/emotional concerns?	Yes	No
Had a significant life event that continues to affect you?	Yes	No

If "Yes" to any of the above, please explain:

AUTHORIZATION

To my knowledge, the information on this form is correct and I am able to participate in all camp activities except as noted. I give permission to the medical professionals selected by the Camp Director to hospitalize, secure proper treatment for, and order injections, anesthesia, surgery or other necessary procedures for me. I grant permission for camp staff to dispense any prescription medications I bring with me, as well as over-the-counter medications as needed. I also grant permission for my picture to be used in camp promotional materials.

Signature of Summer Missionary _____ Date _____

To my knowledge, the information on this form is correct and my child has my permission to engage in all camp activities except as noted. In the event that I cannot be reached in an emergency, I give my permission to the medical professionals selected by the Camp Director to hospitalize, secure proper treatment for, and order injections, anesthesia, surgery or other necessary procedures for my child. I understand I am responsible for the cost of any such medical treatment, whether I have insurance coverage on my child or not. I grant permission for camp staff to dispense any prescription medications which I send with my child, as well as over-the-counter medications as needed. I also grant permission for my child's picture to be used in camp promotional materials.

Signature of Parent/Guardian _____ Date _____

(if Summer Missionary is under 18)