

2012 Camp Galilee Health Form

Camper's Name	DOB	Sex	Age	Health Care Plan
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Parent/ Guardian (name)	Relationship to Camper
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Home Phone	Work Phone	Cell Phone	Email
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Please check if there has been a history of the following:

- | | | | | | |
|--|--------------------------------------|--------------------------------------|---|---|--|
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Fainting | <input type="checkbox"/> Asthma | <input type="checkbox"/> Restricted Diet | <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Other |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Eye Trouble | <input type="checkbox"/> Ear Trouble | <input type="checkbox"/> Recent Flu Systems | | |

Unusual sensitivity to:

- | | | |
|--|---|--------------------------------|
| <input type="checkbox"/> Insect/Bee stings | <input type="checkbox"/> Poison Oak/Ivy | <input type="checkbox"/> Other |
|--|---|--------------------------------|

Church Attended _____ Pastor _____

Health Record

Please fill out entire form and sign; No child will be admitted without a completed health record.

- Our Family does not have insurance. (This will not keep your child from being able to attend camp)

Health Insurance Company _____ Policy Number _____

Employer _____ Policy Holder _____ Insurance Phone _____

Dr. Name and phone number _____

Health Problems/Disabilities _____

My Child may be given: Tylenol, Ibuprofen, Benadryl, antacids, antibiotic cream and any other over-the-counter medications as deemed necessary by the Camp Nurse. Yes No

My Child is up-to date on all state required immunizations Yes No

Has your child been exposed to any communicable disease? If so, name of disease and date _____

List all medication your child is bringing to Camp (continue on separate sheet if necessary)

Medication	Dosage and Time	Time last dose taken
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I request the Camp Nurse administer the prescribed drugs as prescribed Yes No

Or: My child may take his/her own medications as prescribed Yes No

Medical & Liability Release

I have and read and approved the included information. You have my permission for my child to attend Camp Galilee and participate in its activities. I, acting on my own behalf, also release the Minnesota District, Inc and Camp Galilee, it's staff, employees, as well as volunteer workers from any liability whatsoever arising out of property damage or loss as well as injury or sickness or death which may be sustained by my child as the result of any participation in the camping program.. I understand that camp counselor refers to a person in charge of a group of children at a camp and does not imply the person is licensed to give counsel. Parent's/Guardian's signature authorizes emergency treatment in the event of illness/injury if parents are not immediately available, and gives permission authorizing camp personnel to inspect camper's belongings to see they have not brought any prohibited or illegal items.

Signature of Parent or Guardian Required

Date