CROSSWAYS
CAMPING MINISTRIES

2019 CONFIRMATION CAMP
SUMMER ADULT HEALTH HISTORY FORM

Please follow the instructions (all requested information is mandatory to complete):

1. Complete all pages of this form if you are spending the night at camp. Make a copy to keep for your records.
2. Send the original signed form NO LATER than **TWO WEEKS** to the camp you will attend.
3. If you attend multiple sessions during the summer, one-health form per session you attend is needed.

Please check which camp you are attending:

☐ Imago Dei Village
W8160 Cloverleaf Lake Rd.
Clintonville, WI 54929

☐ Pine Lake
W5631 Akron Avenue
Waupaca, WI 54981

☐ Waypost
351 Crooked Lake Rd.
Hatley, WI 54440

Name: _____ ❒ **Male** ❒ **Female**
First Middle Last

Dates attending camp: from _____ **to** _____ ***Birthdate:** _____
(Month/Day/Year) (Month/Day/Year) (Month/Day/Year)

I further authorize Crossways Camping Ministries to use photos, videos or other likeness of the above named for Crossways publicity with no identifying information posted. Please initial here if you **DO NOT** authorize this use: _____

Allergies:
❒ No known allergies.
❒ I am allergic to:
(Please describe what you are allergic to and the reaction seen on back side)
❒ Other, **please explain on back side**

***Diet, Nutrition:**
❒ I eat a regular diet. ❒ I eat a regular vegetarian diet.
❒ I am lactose intolerant. ❒ I am gluten intolerant.
❒ Other, **please explain on back side**

Note: We do our best to accommodate food allergies, intolerances, and specialized diets. However, there may be some accommodations we are unable to provide. Please contact the Camp Director to discuss specific dietary needs and concerns two weeks prior to attending.

Health-Care Providers:
Name of primary doctor(s): _____ **Phone:** (_____) _____

Restrictions:
❒ I have reviewed the program and activities of the camp provided in the camp guide and feel I can participate without restrictions.
❒ I have reviewed the program and activities of the camp provided in the camp guide and feel I can participate with the following restrictions or adaptations. (*please describe on back side)*

Emergency contact to be contacted in case of illness or injury:
Name: _____ **Relationship:** _____
Preferred Phones: (_____) _____ (_____) _____
Home Address: _____
Street Address City State Zip Code

Medical Insurance Information: I am covered by family medical/hospital insurance ❒ Yes ❒ No
Please include a copy of your insurance card; copy both sides of the card so information is readable

Date of Last Tetanus Shot:
(Month/Year)_____

Medication: I will keep my medications: ❒ in the camp-provided lock box that is located in my cabin/room: _____
❒ locked in my car. My car keys are located: _____Car Make/Model:_____
"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies.

Please review camp guide regarding required packaging/containers.
❒ I will not take any daily medication while attending camp. ❒ I will take the following daily medication(s) while at camp:

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			❒ Breakfast ❒ Lunch ❒ Dinner ❒ Bedtime ❒ Other time:		

Please list any past medical treatments you feel we should know about in order to properly aide you in meeting your health needs while at camp *(describe further on back side):*_____

Authorization for Health Care:
This health history is correct and accurately reflects my health status. I give permission to photocopy this form. I give my permission to the physician to treat me in case of emergency.

Signature _____ **Date:** _____