

**Health Form
Upper Peninsula Bible Camp**

ATTENTION: This form should be completed and signed by parents, and must be submitted upon arrival at camp or mailed in advance.

Camper Name _____

Age _____ Birthdate _____ Sex _____

I, (your name) _____, consent to allow UPBC to provide or seek emergency medical or surgical treatment and/or non-surgical, routine medical care of my son/daughter.

(Signature of Parent or Guardian and date signed)

Address _____

Telephone () _____

Alternate emergency phone () _____

THIS BOX FOR CAMP USE
TEMP _____ PULSE _____
RESPIRATION _____
SPECIAL NOTES _____

Health History

Include any physical illness presently being treated under number 15 if it is not listed elsewhere.

Is your child having any of the problems listed below?

	Yes	No		Yes	No
1. Allergies or reactions: (food or other)			9. Shortness of breath		
2. Hay fever, asthma, or wheezing			10. Speech problems		
3. Eczema or frequent skin rashes			11. Menstrual problems		
4. Convulsions / Seizures			12. Allergy to medications		
5. Heart trouble			13. Current communicable diseases		
6. Frequent colds, sore throats, earaches			14. Other:		
7. Diabetes					
8. Trouble with passing urine or bowel movements					

Please explain any problem area identified above: _____

Medications

Please list any medicines (prescription or nonprescription) your child will take at camp. These must be stored in the Health Center and administered by the nurse.

	Medicine name	Dose	How Often
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

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Immunizations

1. My child's immunizations are up to date: yes/no (please circle one)
2. My child's last tetanus booster was (date) _____(Must be within the last 10 years).

Additional Health Information

Does your child have any special emotional problems or physical limitation we need to know about? If so, do you recommend we handle them in a particular way? _____

Health and Accident Insurance Information

Please complete the information below:

(health and accident insurance company name, address, and phone number)

(Subscriber's name, date of birth, and contract number)

(group number, employer name and address)

(dental insurance company name, address, and phone number)