Grace Outside/Michigan Area
United Methodist Camping
PO Box 134
St Johns, Mi 48879
989-534-6587

Adult Health Form

Campers/volunteers over 18 and camp staff must submit a completed form for themselves

For Office Use | Date completed

Name: Last _____ First _____ Nickname _____

Street Address_____ City_____ State _____ Zip _____

Phone # (Cell preferred) Parent 1 (_____) _____ - _____ Date of birth mm/dd/yyyy _____

Emergency Contact

Name_____ Relationship _____

Emergency Contact Number (cell preferred) (_____) _____ - _____

AUTHORIZATION Please read and sign, indicating your authorization:
Routine Care: I grant permission for the Health Officer to give me first aid and treat illnesses in accordance with the camp's Standard Care Procedures approved yearly by a physician.

Emergency Care: I grant permission to the camp Health Officer to secure emergency medical/surgical treatment, if necessary, for the person named on this form while at camp. I give permission to be transported for treatment, if the Health Officer deems it safe, in a private camp vehicle, or by ambulance if indicated for my safety. Costs associated with illness/injury-the camp will not be responsible for any costs incurred as a result of treatment or transportation due to illness or injury.
Assumption of Risks: Having read the camp description, I understand there are risks inherent to camping activities (outdoor activities, sports, aquatics, etc.).

Signature: _____ Date _____

INSURANCE: Are you covered by medical/hospital insurance? □ yes □ no

Please bring a front-and-back photocopy of your insurance card to check-in at camp, OR complete the fields below
Name of primary insurance provider_____ Name of Health Insurance Company _____

Contact Number:_____ Plan Code: _____ Group Number:_____
Primary Physician:_____ Phone number: (_____) _____ - _____

Allergies ☐ I have no known allergies

Food allergies. Describe food, reaction and management

Environmental allergies Describe reaction and management

Medication allergies. Describe reaction and management

NUTRITION: The camp kitchen can work to accommodate food allergies and most medically prescribed diets, but can not cater to individual food preferences Describe any dietary needs or restrictions. (Vegan, Vegetarian, Gluten, lactose intolerant) Contact the camp 2 weeks prior to camp to make arrangements.

Medications: Medications must be given to the camp Health Officer at check-in for dispensing at the designated times. All medications (over the counter and prescription) by law must be locked securely in the Camp Health Center if you are in a living situation with campers. Talk with the Health Officer for exceptions (inhalers, epi pens) ALL MEDICATIONS MUST BE SENT IN THEIR ORIGINAL CONTAINERS, LABELED FOR YOU WITH MEDICATION NAME, DOSAGE/FREQUENCY TO BE GIVEN AND THE NAME OF THE PRESCRIBING PHYSICIAN ON THE LABEL Medications are dispensed at meals and bedtime unless it is critical, they be given at a different time (anti-seizure, heart meds, psych meds)

Please list medications to be given at camp, both prescription and non-prescription. State the drug name, dosage, frequency, time of day to be given

Medication #1:_____

_____

Medication #2::_____

_____

Medication #3::_____

_____

Medication #4::_____

_____

Medication #5::_____

_____

Medication #6 :_____

_____

Inhalers used as needed □ Kept (report to the health officer when used) □ Given to Health Officer

Are you taking any medications that might affect your ability to perform the functions of your job description? □ yes □ no
(Discuss with the camp director if yes)

The camp stocks the following medication. Please do not send additional amounts unless given routinely.
Acetaminophen (Tylenol) Ibuprofen (Motrin) Diphenhydramine (Benadryl) Decongestant, Allergy medicine-loratadine (Claritin), Antacid, Cepecol throat lozenges, Calamine lotion, Cough drops, Cough suppressant, Imodium (Anti-diarrhea) Hydrocortisone Cream

Please Check one □ It is ok to give me these if indicated per camp Standard Orders

□ It is ok to use these meds except _____

HEALTH CONDITIONS:

Please check all that are applicable.

□ Have a chronic illness/condition (ear aches, sore throats)
□ Have had a seizure
□ Have asthma, wheezing, hay fever
□ Have diabetes
□ Have Arthritis
□ Have an irregular heart beat
□ Have a heart defect/heart disease
□ Have had a recent injury, illness, surgery
□ Have had or have a back pain/injury
□ Have had a concussion
□ Have hypertension
□ Allergic to bee stings
□ Smoke
□ Have had Flu, COVID immunizations

Date of last tetanus shot_____

□ Have a diagnosis of depression, Panic/anxiety disorder or other psychiatric diagnosis

Describe any activity restrictions and/or other past, or ongoing medical care or conditions not listed

Signature_____ Date_____