Health History Form
Operation Purple® Camp Ellensburg

All campers: confidential information, please print clearly (in ink)

This completed form should be sent in to the Lazy F office by **JUNE 1st** so that the camp staff can be aware of your needs. Attach additional pages if needed.	**Mail this form to the address below:** *Operation Purple*® Camp Lazy F Camp and Retreat Center 16170 Manastash Road Ellensburg, WA 98926
Camper's Name:	Birthdate (M/D/YYYY)
Address	Gender (circle one) Male Female
City/State:	Zip:
Parent/Guardian Name (s):	
Evening phone: ( ) Day/Work Phone ( ) Cell Phone ( )	
Address *(if different)*	City/State: Zip:
Emergency Contact, (other than parent/guardian):	Phone ( )
Address *(if different)*	City/State: Zip:
Cell Phone: ( )	Relationship to Camper:
Does camper have any known allergies? (circle one) YES NO	
Allergies to Medications:	
Food Allergies:	
Other Allergies:	
List any dietary restrictions:	

Health History (WITHIN THE LAST THREE YEARS, CHECK ANY THAT APPLY):

	Epilepsy or seizures		Frequent sore throats		Black pain or strain		Frequent ear infections
	Headaches		Alcohol/drug addiction		Menstrual problems		Bed-wetting
	Attention Deficit Disorder		Asthma		Heart disease		Diabetes (type 1 or 2)
	Tobacco usage		Eating disorders		Nightmares		Hyperventilation
	Hyperactivity		Sleep walking		Severe allergic reaction		Self-mutilation

Other:

Pertinent Past Medical Treatment:

Is camper presently taking or using any type of medication(s) or drug(s)? (circle one) YES NO

(If "yes" you will need to complete the "Permission to Administer Medications and Administration of Medication" form on opposite side)

PLEASE PROVIDE A RECORD OF IMMUNIZATIONS

Is the camper on all immunizations needed for school? YES NO	Date of last tetanus shot	Blood Type:
Does the camper have a health condition (e.g. allergies, chronic conditions) or special circumstances which may affect program participation, special housing need, or anything we ought to now prior to emergency treatment? (circle one) YES NO		
Family Medical Insurance: YES NO	Name of Insured:	
Carrier:	Group #:	Phone: ( )
Name of Family Physician:	Phone: ( )	

My child has permission to take part in all camp activities under supervision unless limitations are noted above, and I agree that the camp or camp personnel will not be held responsible for accidents arising there from. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for my child. I either have appropriate insurance or, in its absence, agree to pay all the costs of medical services as may be incurred on my camper's. In an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed health form may be photocopied for trips out of camp.

I, the undersigned parent/guardian, give permission for the above named camper to participate in the camp indicated above. I recognize and acknowledge that camping activity can involve certain hazards, including, but not limited to, illness, injury, and accidents, and release The United Methodist Church from liability.

I GIVE PERMISSION FOR:
-Photocopying of health history form
-Photos/video to be used in future publicity
-Camper's name, and e-mail address to be included in an address list

Signature of parent/guardian	Date:

Camper's Name:	*Operation Purple*® June 26 – July 1st

Permission to Administer Medications and Administration of Medication
Operation Purple® Camps

I give my permission to the Camp Health Care Provider or his/her designate to give the following medications (or their generic equivalents) to my child,_____, in accordance with recommended package dosing for the specific indications below. These medications are available at camps and need not be brought by participants.

	YES	NO		YES	NO
Tyenol: Mild fever or discomforts	_____	_____	Benadryl: Allergy symptoms	_____	_____
Ibuprofen: Mild fever or discomforts	_____	_____	Sudafed: Allergy symptoms	_____	_____
Throat Lozenges: coughing/sore throat	_____	_____	Antacid: Upset stomach	_____	_____
Topical Creams: itching, sunburn or insect bites	_____	_____	Anti-diarrheal: for diarrhea	_____	_____
Permission to follow recommendations by Washington Poison Center or Idaho Poison Control:				_____	_____

Please add an additional page if needed.	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun.
Medication: Dosage: Time to give: Reason for taking:							
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If your child will be on a "med holiday", we ask that you please send the medication to camp. If it appears that your camper would benefit from being on their medication, we will have the Camp Health Care Provider be in contact with you.

Identify any medications that the camper does not/may not take during this camp:

IMPORTANT INFORMATION: PLEASE KEEP ALL MEDICATION (*prescription* AND *over-the-counter)* IN THE ORIGINAL CONTAINER that identifies; the prescribing physician (if appropriate), the name of the medication, the dosage, and the frequency of administration. All medications must be checked in to camp staff upon arrival.

I hereby authorize the Health Care Provider for Lazy F Camps to administer the above listed medications to my child/dependent during their time at camp. I have given the Health Care Provider dosage and administration instructions.

Note: The Camp personnel will notify you if your child displays the following symptoms:
*Any illness that persists longer than 24 hours; including fevers, coughs, excess expulsion of bodily fluids, allergic reactions, severe tiredness
*Andy injury that causes severe prolonged pain, discoloration and/or swelling
*Any condition that cannot be sufficiently treated by camp personnel
*Any condition requiring transport to other medical services

Parent/Guardian Signature:	Date:

Upon Camper	**Health History Form Verified**	Date:	By:	(initial)
Check In	**Administration of Meds rec'd**	Date:	By:	(initial)