Crystal Springs Camp

Registration and Health Form

Date of Form _____

21 Crystal Springs Camp Road
Kelso, TN 37348
931-937-8621
www.crystalspringscamp.org

T-Shirt Size_____

Camp or Group Name

_____

Rec Group #

Study Group #

Cabin #

Name

Camper Name_____ Date of Birth_____ Age_____ Gender_____

Home Address_____
city state zip

Phone_____ Social Security # _____ EMAIL_____

Church Name_____

Pastor_____ Phone_____

Parent/Guardian Name _____

Address (if not same)_____
city state zip

Work Address_____
city state zip

Phone#: Home_____ **Work**_____ **Other** _____

Alternate Emergency Contact _____ **Phone**_____

Address_____
city state zip

Insurance Information

Is the Camper covered by a health insurance policy?_____ Health Insurance Company _____

Policy #_____ Group #_____

Please Attach a copy of the front and back of health card to this Form.

THE CAMPER COVENANT– Must be signed to attend camp

As a camper at this camp, I agree to abide by all camp rules and requirements, and to actively participate in all camp activities. I realize that I am financially responsible for any camp property that is destroyed or defaced. I understand that breaking this covenant could result in discipline action by the directors or in my being sent home.

Camper Signature_____ Date_____

PARENTS OR GUARDIANS AUTHORIZATION– Must be signed in order for camper to attend.

I give permission for the camper to participate in all camp activities. I do acknowledge that the health history on this form is complete and correct to my knowledge. I give permission for the camp to provide the necessary medical treatment needed for the camper including: routine health care, administering medications, seeking emergency treatment, including ordering x-rays or routine tests.

I give permission for the camper to ride on transportation provided by the sponsors of this camp (Group renting camp facilities). I agree that I will not hold the Camp, Group, owners of vehicles or drivers responsible for any injury suffered by the camper due to his or her own negligence.

In case of medical emergency, I understand that every possible effort will be made to contact parents or guardian. In the event I cannot be reached, I give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for the above named camper.

Parent or Guardian Signature_____ Date_____

PICTURE AUTHORIZATION

I give permission for my youth's picture to be taken, and it may also be used on the Crystal Springs Camp Web site and to possibly be used in future camp promotional material

Parent or Guardian Signature _____ Date _____

HEALTH HISTORY

MEDICATIONS BEING TAKEN

Please list all medications taken on a routine basis including over the counter and non prescription drugs.

IMORTANT: Bring enough medication to last the duration of camp. Please keep it in the original packaging or bottle that identifies the Physician prescribing the drug, the name of medication, the dosage, and frequency of administration.

Check one of the boxes

This camper is currently taking no medications on a routine basis.

This camper currently takes the following medication

Name of drug _____ Dosage _____ # times taken each day_____

Medical reason for taking the drug_____

Name of drug _____ Dosage _____ # times taken each day_____

Medical reason for taking the drug_____

Name of drug _____ Dosage _____ # times taken each day_____

Medical reason for taking the drug_____

ALLERGIES(please list all that are known) Describe reaction and treatment normally taken.

Medication

_____ _____
_____ _____
_____ _____

Food

_____ _____
_____ _____
_____ _____

Other

_____ _____
_____ _____
_____ _____

RESTRICTIONS

Please list any dietary restrictions this camper has:_____
_____
_____

Please list any Physical restrictions (things the camper cannot do) _____
_____
_____
_____

Rate the camper's ability to Swim: ___Excellent ___ Fair ___ Poor ___ Cannot swim

GENERAL QUESTIONS

Which of the following has the camper had:

___Measles ___ Chicken Pox ___ German Measles ___ Mumps ___ Hepatitis A ___ Hepatitis B ___ Hepatitis C

Give the most recent dates of the following immunizations:

DTP	_____	Tetanus	_____	Polio	_____
Mumps/Measles/Rubella	_____	Hepatitis	_____	TD-Tetanus/Diphtheria	_____
Chicken Pox	_____				

PLEASE ANSWER THE FOLLOWING QUESTIONS YES OR NO,

	DOES OR HAS THE CAMPER:	YES	NO			YES	NO
1	Had a recent injury illness or infectious disease?	☐	☐	15	Had frequent headaches?	☐	☐
2	Have a chronic or recurring illness or condition?	☐	☐	16	Had surgery?	☐	☐
3	Been hospitalized	☐	☐	17	Had problems with body joints?	☐	☐
4	Been diagnosed with heart murmor?	☐	☐	18	Have an orthodontic appliance that will be brought to camp?	☐	☐
5	Had back problems?	☐	☐	19	Had a eating disorder?	☐	☐
6	Had high blood pressure?	☐	☐	20	Have a history of bed-wetting?	☐	☐
7	Had chest pain during or after exercise?	☐	☐	21	If female, have an abnormal menstrual history?	☐	☐
8	Had seizures?	☐	☐	22	Have problems sleepwalking?	☐	☐
9	Been dizzy during or after exercise?	☐	☐	23	Had problems with diarrhea or constipation	☐	☐
10	Passed out during or after exercise?	☐	☐	24	Had mononucleosis in last 12 months	☐	☐
11	Had frequent Ear infections	☐	☐	25	Have asthma?	☐	☐
12	Wears glasses, contacts or protective eye wear?	☐	☐	26	Have diabetes?	☐	☐
13	Been knocked unconscious?	☐	☐	27	Have any Skin problems?	☐	☐
14	Had a head injury?	☐	☐	28	Had emotional difficulties that required professional help?	☐	☐

Please explain the yes answers to the above questions noting the question number:_____
_____
_____
_____
_____

Name of Family Physician:_____

Address:_____

Phone :_____

Any other information the directors of the camp should know about the physical, emotional, or mental health about the camper:_____
__
_____
_____
_____
_____
_____

PHYSICAL NEEDED ONLY IF REQUIRED BY INDIVIDUAL CAMP GROUP

PHYSICAL APPROVAL BY A PHYSICAN OR LICENSED MEDICAL PERSONNEL

Date of Examination_____(MUST NOT BE MORE THAN 24 MONTHS PRIOR TO CAMP DATE)

In My opinion, _____, IS____ or IS NOT_____ able to participate in an active camp program.

Name of Physician or Licensed Medical Personnel (Print)_____

Address_____

Title_____ Phone_____ Date_____

Signature _____