

2024 Faith Church Summer Camp

Personal Medical History Form

Please print clearly in ink

Name: _____

Address: _____

Home phone: _____ Cell Phones: _____

Date of Birth: _____

Name of Parent or Guardian: _____

Parent / Guardian Work Phone No.: _____

Name of Person to be Contacted if Parent / Guardian cannot be reached:

Phone No.: _____

Relationship to Child: _____

Child's Name: _____ Age: _____

Known allergies: _____

Is your child currently taking any medications? Yes No

If so, please list the name of the medicine and the dosage:

Has your child ever had any of the following ailments? (Please circle those which apply)

ASTHMA
HAY FEVER
BRONCHITIS
CHRONIC SINUS INFECTIONS
CHRONIC EAR INFECTIONS
STREP THROAT
KIDNEY INFECTIONS
ULCERS
FAINTING SPELLS
HEPATITIS
MOTION SICKNESS

HIGH BLOOD PRESSURE
HEART DISEASE
DIABETES
LOW BLOOD SUGAR
ANEMIA
MIGRAINE HEADACHES
INSOMNIA
SLEEPWALKING
MONONUCLEOSIS
FREE-BLEEDING

Has any member of your child's immediate family (birth father, birth mother, sister, brother) ever had any of the following?: (Please circle those which apply)

ALLERGIC REACTION TO MEDICINES, FOODS, ANIMALS, OR INSECT BITES
(If yes, please explain: _____)

DIABETES
HEART ATTACK

HIGH BLOOD PRESSURE
FREE-BLEEDING

List other serious medical problems occurring in the immediate family:

Has your child ever had surgery? Yes No

If yes, please list: _____

Approximate date of surgery: _____

Has your child ever had a broken bone? Yes No

If yes, please list: _____

Does your child have any metal implants in his/her body? Yes No

If yes, please list: _____

Does your child wear contact lenses? Yes No Dentures? Yes No

Any type of bridgework, retainers, etc.?

DATE OF LAST TETANUS SHOT? _____

My child has my permission to ask for and take (*with the supervision of a camp leader*) any of the following over-the-counter medications indicated below:
(Please circle **yes** or **no** by each item listed)

- | | | |
|-----|----|---|
| Yes | No | Tylenol |
| Yes | No | Anti-inflammatory / Anti-cramp (Advil, Aleve) |
| Yes | No | Pepto Bismol |
| Yes | No | Cough Syrup / Coughdrops |
| Yes | No | Antacids / Anti-gas (Maalox / Mylanta) |
| Yes | No | Motion Sickness (Dramamine) |
| Yes | No | Antihistamine (Benadryl, Chlortrimeton, Tavist, Claritin) |
| Yes | No | Decongestant (Sudafed, Claritin D) |
| Yes | No | Anti-diarrhea (Imodium A-D) |
| Yes | No | Laxative (Senokot) |

(Note: Generic Brands may be used)

Additional over-the-counter medicines your child may need must be turned into the Camp Leader at check-in. Please leave them in their original container and label each with your child's name.

I understand that all medicines are to be turned into the Faith Church Summer Camp Team upon arrival at the Church. **All prescription medicines should be left in their original container with the prescription label on it.** The taking of **ALL** medicines will be supervised by a Youth Leader (the only exception to this rule will be for asthma inhalers or nitroglycerin tablets). This policy is for your child's safety and the safety of other children in the group.

Signature of Parent / Legal Guardian: _____

Printed Name of Parent / Guardian: _____

Date: _____