

WEST COAST CAMP HEALTH AND ACTIVITY RECORD

Vertical Life Fellowship, Inc. Redding, CA 96002

Revision 6/25/2012

Please complete, sign, and date this form for all campers. **Do not mail. Do not fax. Form must be turned in upon arrival.**
 (If form is incomplete, parents or guardian will be called collect.) *Please Print*

LAST NAME			FIRST NAME			MIDDLE INITIAL			
SOCIAL SECURITY NUMBER		DATE OF BIRTH		MALE	FEMALE	DATES ATTENDING CAMP			
				<input type="checkbox"/>	<input type="checkbox"/>				
Group Information:									
Group Name						Group Leader			
Leader Phone Number: Home ()			Work ()			Cell ()			
Parent or Guardian	Full Name:						Telephone Numbers With Area Codes		
							Home ()		
	Address						Work ()		
	City			State			Zip code		
	Email:								
IF NOT AVAILABLE IN AN EMERGENCY NOTIFY: (PREFERABLY RELATIVES)						Telephone Numbers With Area Codes			
Name						()			
Name						()			
Family Health Insurance Information	Name of Company					Policy/Group Number			
	Contact Person					Telephone Number			
						()			
	Parents/Guardian Social Security Number (Required by Medical Facilities if under 18 years old)								
Parent/Guardian Name					Social Security No:				
SPECIAL MEDICAL PROBLEMS, CONDITIONS OR RESTRICTIONS:									
LIST MEDICINES? (STATE LAW REQUIRES THAT ALL MEDICATIONS, INCLUDING VITAMINS, TYLENOL, ETC, BE GIVEN TO THE CAMP NURSE. ALL MEDICATIONS <u>MUST</u> IN THEIR ORIGINAL CONTAINERS.									
MEDICATIONS ALLERGIC TO AND OVER THE COUNTER MEDICATIONS YOUR CAMPER MAY NOT HAVE: <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Aspirin <input type="checkbox"/> Other (Please list)									
ANY FOOD ALLERGIES? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, explain.									
IS CHILD TROUBLED WITH BED-WETTING? YES <input type="checkbox"/> NO <input type="checkbox"/>									
ABLE TO PURSUE ALL NORMAL ATHLETIC ACTIVITIES? YES <input type="checkbox"/> NO <input type="checkbox"/> If no, explain.									

IF CAMPER HAS HAD ANY OF THE FOLLOWING PLEASE CHECK THE BOX AND INCLUDE YEAR OCCURRED:

- | | | |
|------------------------------------------------------------|-----------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Chorea | <input type="checkbox"/> Chronic Intestinal Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Insulin | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Frequent Colds |
| <input type="checkbox"/> Non-Insulin | <input type="checkbox"/> Frequent Sore Throats | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Infectious Jaundice/
Hepatitis | <input type="checkbox"/> Inflammatory Bowel Disease | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Malaria | <input type="checkbox"/> Malignancy |
| <input type="checkbox"/> Operations | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Otitis Media |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Polio Myelitis | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Rubella (German) | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Speech Defect | <input type="checkbox"/> Tuberculosis or TB Contact |
| | <input type="checkbox"/> Whooping Cough | |

Proof of immunization, required by law, must contain **SPECIFIC REFERENCES** to those diseases, dates and doses. Immunizations must be updated if not in accordance with state regulations.

- **Proof of Measles** means two doses of measles vaccine on or after your first birthday and at least 30 days apart (preferably three months), and/or a physician-documented history of the disease or serologic evidence of immunity.
- **Proof of Rubella** means one dose of rubella vaccine on or after your first birthday or serologic evidence of immunity.
- **Proof of Mumps** means one dose of mumps vaccine on or after your first birthday, a physician-documented history of the disease, or serologic evidence of immunity.

IMMUNIZATION HISTORY		1st Dose	2nd Dose	3rd Dose	4th Dose	Last Dose
Diphtheria & Tetanus Toxoid DT Five or more doses required. Most recent dose must be within 10 years prior to entry.						
Polio Vaccine 5 (Live Oral Sabin) Minimum of four doses for those 18 years of age or under for those 19 and over, record previous doses, but no additional doses should be given.						
Refer to Immunity Schedule Printed Above	Measles			Individuals will not be allowed to attend camp without complete immunization history		
	Mumps					
	Rubella					

The health and immunization history is correct so far as I know. My son/daughter has permission to engage in all prescribed camp activities which include but are not limited to horseback riding and/or water skiing (if applicable), except as noted by me and the examining physician and has permission to leave the camp grounds for camp related outings and purposes. I realize that my campers picture and/or testimony may be used in the future promotion of Vertical Life.

Vertical Life Camps are a non-profit charitable organization dependent on God and His people. Those who use Vertical Life's facilities and /or engage in related activities waive and release Vertical Life Fellowship, Inc. from any claim for personal injury or property damage. Attendees agree to carry insurance and/or cover the expenses related to personal injury or property damage.

Illegal drugs, weapons and similar items are not permitted at camp. Vertical Life reserves the right to search for and remove such items from anyone suspected of possessing them. I understand that all medications, vitamins, etc must be given to the camp nurse upon arrival and that they must be in the original containers.

I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests and treatment for my son/daughter. In the event I cannot be reached I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection, anesthesia, and/or surgery for my child as named above. I hereby give permission for the camp nurse to administer over the counter medications to my child per manufacturers guidelines except as noted above.

Campers wishing to leave early must be picked up by parent(s) who sign this health form. Anyone other than the parent must have written permission signed by the same parent who has signed this form. The camp reserves the right to refuse dismissal without proper identification.

Signature of Father/Guardian(s): _____ **Date:** _____

Signature of Mother/Guardian(s): _____ **Date:** _____