Quest/Horizon Medical Form

Camper Name:_____ Birthday:(mm/DD/YY) _____

Parent/Guardian 1:_____Relationship to camper:_____

Preferred Phones: (_____)_____ (_____)_____

Parent/Guardian 1:_____ Relationship to camper:_____

Preferred Phones: (_____)_____ (_____)_____

Additional contact in the event that the parents/guardians can't be reached

Name:_____ Relationship to camper:_____

Preferred Phones: (_____)_____ (_____)_____

Allergies ☐ No known allergies

This ☐ camper is allergic to: ☐ Food ☐ Medications ☐ Environmental (bee stings, hay fever, etc.)

(Please describe the allergy, whether the allergy is caused by ingestion, touch or airborne and what the level of allergy is (mild, severe or anaphylactic)

Does the camper use an inhaler: ☐ Yes ☐ No If so, what kind:_____

Does the camper carry an epi-pen: ☐ Yes ☐ No

Camper Health History– Please circle the as appropriate

Has the participant ever had bleeding/ clotting disorders?	Yes	No	Does the participant have a seizure disorder?	Yes	No
Does the participant have any physical impairments?	Yes	No	Does the participant have diabetes?	Yes	No
Does the participant have asthma?	Yes	No	Does the participant have vision impairments?	Yes	No
Does the participant have headaches?	Yes	No	Does the participant wear glasses, contacts or protective eyewear?	Yes	No
Has the participant been treated for ADD/ ADHD?	Yes	No	Does the participant have problems with fainting or dizziness?	Yes	No

Activity Restrictions : Does the camper have any restrictions to participating in activities, be it physical, mental or behavioral? ☐ Yes ☐ No If so, please explain restriction or adaptation needed:

Medical Insurance Information

This camper is covered by health insurance: ☐ Yes ☐ No

Insurance Company:_____ Policy #:_____

Subscriber: _____ Insurance Co. Phone #:_____

Camper Medications– Please list any medications the camper is currently taking and dosage:

Medication	Dosage	Reason for Taking

What else should we know? Please provide any additional information that would be helpful for staff to know for your camper to have a successful week.

Parent/ Guardian Authorization for Health Care

The Participant's medical conditions and information stated on this application is complete and correct. I give permission to my church, and conference staff to (1) provide appropriate first aid for minor injuries; and (2) seek further treatment from local physicians or hospitals if the medical condition warrants. In the event I cannot be reached in an emergency, I also give permission to the treating physician to examine, diagnose, and treat or secure proper treatment for the Participant and hospitalize, and to order injection and/or anesthesia and/or surgery for the Participant, as the physician shall determine proper and necessary under the circumstances. I agree to assume full financial responsibility for the costs of any evacuation and/or medical treatment that the Participant may receive. A photocopy of this consent shall be as valid and may be accepted as the original.

I certify that I have completed all sections of this Health Form and accept full responsibility for any errors or omissions. The Participant has permission to take part in all program activities except as noted above. I understand the information on this form will be shared on a "need to know" basis with my church leaders and conference staff.

I fully understand that the Participant is to abide by all rules governing personal conduct during all activities. Any violation of these rules may result in the Participant being sent home at the expense of his/her parent/guardian. I understand that no refunds will be given for Participants sent home due to disciplinary procedures or illness and that it is my responsibility to pick up a Participant sent home for such a reason.

Signature of

Parent/Guardian:_____ Date:_____

Name (please print):_____