



# REACH MEDICAL FORMS HEALTH HISTORY

For all participants - to be completed by parent or legal guardian if under age.

For additional space please use the reverse side of this form or attach additional pages. Today's date: \_\_\_\_\_

Name:

Last	First	MI	Age:	Date of Birth: / /	Weight:
------	-------	----	------	--------------------	---------

### INSURANCE INFORMATION (REQUIRED) - *Please attach copies of Cards or Insurance Coupons*

Insurance Company:	Name of Insured:
ID#:	State insurance held:
Primary physician's name:	Physician's phone number:
Location of primary physician: city/state:	Date form filled out:
Date of most recent physician visit:	Concerns:

- Please list any significant medical conditions:
  
- Dietary restrictions:
  
- Food allergies/intolerances\*: Meals offer delicious, varied and nutritionally sound choices, with options to meet most dietary restrictions. If you have other concerns and need to supplement meals with your own food, please contact REACH. REACH is not responsible for meeting unique needs not disclosed in advance on this form.
  
- Allergies to medications:
  
- Restrictions (i.e. activities prohibited):
  
- Other concerns (e.g. bed wetting):
  
- Does this patient have a compromised immune system?  Yes, Illness:  No  
 If yes, please attach laboratory data sheet.  
 For HIV-positive children, is the patient aware of his/her status?  Yes  No

# REACH MEDICAL FORMS / HEALTH HISTORY – PAGE 2

Name: \_\_\_\_\_ / /  
 Last First MI Age: Date of Birth: Weight:

**IMMUNIZATION HISTORY:** (Required immunizations must be determined locally)

- I verify that the patient’s immunizations are current according to the Washington State requirements.
- I verify that this patient has no signs or symptoms of active Tuberculosis infection.
- This patient is behind on the following immunizations:
  - HIB  DTAP
  - MMR  Hepatitis B
  - IPV

8. List all medications (All medication must be checked in with the Camp Physician. Refrigeration is available in the medical building.)

Medication Name	Dose	Route	Times Taken

For additional space please use the reverse side of this form, or attach additional pages.

## AUTHORIZATION FOR PARTICIPATION AND MEDICAL TREATMENT

To be completed by parent or legal guardian if under age.

Camper Name: \_\_\_\_\_ Age: \_\_\_\_\_  
 Last First

*I verify that I am age 18 or older, or am the parent or legal guardian of the youth named above and do hereby give my permission for me/him/her to engage in all activities excepted as noted by the examining physician and indicated on the medical health history and physical form. In consideration of the benefits to be derived, I expressly waive all claims against REACH Ministries, its staff, its officers, directors, trustees, volunteers, and their heirs and assign, on account of any accident, injury, and/or illness that may occur to myself or my child(ren) during camp, REACH sponsored activities, and/or in travel. I give permission to the physician selected by the camp, to order medical treatment for myself or my child in case of any emergency and in the treatment of pain and/or discomfort. I will be responsible for all costs incurred for care that is not provided by the REACH Camp. This Authorization is effective for one year from the date of signature.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Camper (over 18) or Parent / Legal Guardian

Parent / Legal Guardian Name: \_\_\_\_\_  
 Last First

Guests under age of 18 are required to have their parent/guardian complete and sign this form.