

**PILGRIM LODGE JUMP START WORK DAY – YOUTH GROUP OVERNIGHT  
PERMISSION SLIP**

Please bring this form as well as the completed health form 1.

I, \_\_\_\_\_ as parent or legal guardian give my permission for  
\_\_\_\_\_ to participate in (check all that apply):

\_\_\_\_ **Friday night** overnight at Jump Start Weekend, April 23-24, 2010 This part of the weekend is under  
the supervision of the youth group from (church and town) \_\_\_\_\_

I understand that the youth group leader \_\_\_\_\_ is in charge of supervision of my child during the overnight event.

\_\_\_\_ **Jump Start Work Weekend** at Pilgrim Lodge, April 24, 2010. I understand my child will be working to open the summer camp and that there is some risk in doing manual labor.

\_\_\_\_ **The Youth Group Overnight at PL.** April 24-25, 2010 This part of the weekend is under the supervision of the youth group from (church and town) \_\_\_\_\_

I understand that the youth group leader \_\_\_\_\_ is in charge of supervision of my child during the overnight event.

**Participant Release/Assumption of Risk Agreement/Agreement to Indemnify & Hold Harmless/Certification of Agreement:** Each person signing below understands that participation in the Maine Conference of the United Church of Christ (“Maine Conference”) program can involve the risk of damage and injury, including serious injury, to both people and property. Each person signing below understands and agrees that Maine Conference, its agents, officers and employees, accept no responsibility, and will not be liable, for any injury, harm or damage to his/her person or property (including, but not limited to, injury, harm or damage caused by negligence of Maine Conference, its agents, officers or employees) occurring during or arising out of participation in any Maine Conference program. To the fullest extent permitted by law, each person signing below agrees to assume all risk of injury, harm or damage to his/her person or property arising during or in connection with said Maine Conference program. Each person signing below hereby releases and agrees to indemnify and hold harmless Maine Conference, its agents, officers and employees, from any and all liability, actions, damages and claims of any kind and nature whatsoever for any injury, harm or damage to his/her person or property (including, but not limited to, injury, harm or damage caused by negligence of Maine Conference, its agents, officers or employees) that may arise or occur during or in connection with said program. Each person signing below has read through all the rules, regulations and policies contained in the 2010 Pilgrim Lodge brochure. Each person signing below further understands and agrees to abide by these rules, regulations and policies at all times. In addition, each person signing below is aware that a list of camper names and addresses is distributed to event participants at the end of camp (phone numbers are not included). Each person signing below permits the Maine Conference to use images of me or my child taken at Pilgrim Lodge or its camp trips in promotion of Maine Conference programs, including, but not limited to, future camp brochures, promotional slide shows, video presentations and the Pilgrim Lodge website. I give my permission for any medical personnel or institution to treat my child in the event of an emergency.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(parent or guardian)

# Pilgrim Lodge Camper Health History for CHILDREN, FORM 1

(page 1 of 3) To be completed by parents.  
(Children also need form 2 to be completed by a licensed physician)

Developed and reviewed by *American Camp Association American Academy of Pediatrics Council on School Health & Association of Camp Nurses*

Mail at least two weeks prior to event to:

**Pilgrim Lodge - Health Form**  
103 Pilgrim Lodge Lane  
West Gardiner, ME 04345

Dates attending camp: from \_\_\_\_\_ to \_\_\_\_\_

Camper Name: \_\_\_\_\_

Male  Female Date of Birth \_\_\_\_\_

To Parent(s)/Guardian(s): Attach additional information if needed.

- 1) Complete pages **1, 2, & 3** of this form (Form 1) and **make a copy**
- 2) Send the original, signed **FORM 1** to camp two weeks before arriving.
- 3) Complete the top of FORM 2 (Camper Health Care Recommendations) and provide the copy of FORM 1 With FORM 2 to your child's health care provider for review and completion
- 4) If your child carries an **inhaler, epi-pen** or other medication on his or her person, fill out the bottom section of FORM 3, have the physician fill out the top section.
- 5) Return Form 2 (and if applicable FORM 3) completed and signed by your child's health-care provider, camp at least two weeks before arrival.

Camper Home Address: \_\_\_\_\_  
Street Address City State Zip Code

**Parent/guardian with legal custody to be contacted in case of illness or injury:**

Name: \_\_\_\_\_ Relationship to Camper \_\_\_\_\_ Preferred Phones (\_\_\_\_) \_\_\_\_\_, (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_ Address: \_\_\_\_\_  
(if different from above)

**Second parent/guardian or other emergency contact:**

Name: \_\_\_\_\_ Relationship to Camper \_\_\_\_\_ Preferred Phones (\_\_\_\_) \_\_\_\_\_, (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_ Address: \_\_\_\_\_  
(if different from above)

**Additional contact in the event parent(s) or guardian(s) cannot be reached**

Name: \_\_\_\_\_ Relationship to Camper \_\_\_\_\_ Preferred Phones (\_\_\_\_) \_\_\_\_\_, (\_\_\_\_) \_\_\_\_\_

**Allergies:**  No known allergies  This camper is allergic to:  Food  Medicine  Environmental agents  
*(please describe below what the camper is allergic to and the reaction seen.)*

**Diet, Nutrition:**  This camper eats a regular diet.  This camper eats a regular vegetarian diet.  
 This camper has special food needs *(Please describe below, continue on back if necessary)*

- I have reviewed the program and activities of the camp and feel the camper can participate without restrictions  
 I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations  
**(Please describe, continue on back if necessary.)**

**Medical Insurance Information:** This camper is covered by family medical/hospital insurance  Yes  No  
**Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.**

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Subscriber \_\_\_\_\_ Insurance Co. Phone No. (\_\_\_\_) \_\_\_\_\_

**Parent/Guardian Authorization for Health Care:**

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

*If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.*

Camper Name \_\_\_\_\_

(For Camp Use) Cabin \_\_\_\_\_

# CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

Camper Name: \_\_\_\_\_  
 First Middle Last

Birth Date: \_\_\_\_\_  
 Month/Day/Year

**Immunization History:** Provide the month and year for each immunization. Starred (★) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, tetanus, pertussis ★ (DTaP) or (TdaP)						
Tetanus booster ★ (dT) or (TdaP)						
Mumps, measles, rubella ★ (MMR)						
Polio ★ (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)	<input type="checkbox"/> Had chicken pox Date: _____					
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test Date: \_\_\_\_\_  Negative  Positive

**If your camper has not been fully immunized, please sign the following statement:** I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

**Medication:**  This camper will not take any daily medications while attending camp.  
 This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. **Please review camp instructions about required packaging/containers. Many states require original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.**

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. **Cross out those the camper should not be given.**

- |   |   |
|---|---|
| Acetaminophen (Tylenol)                                   | Ibuprofen (Advil, Motrin)                                     |
| Phenylephrine decongestant (Sudafed PE)                   | Pseudoephedrine decongestant (Sudafed)                        |
| Antihistamine/allergy medicine                            | Guafenesin cough syrup (Robitussin)                           |
| Diphenhydramine antihistamine/allergy medicine (Benadryl) | Dextromethorphan cough syrup (Robitussin DM)                  |
| Sore throat spray   | Generic cough drops   |
| Lice shampoo or cream (Nix or Elimite)                    | Antibiotic cream  |
| Calamine lotion   | Aloe  |
| Laxatives for constipation (Ex-Lax)                       | Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol) |

# CAMPER HEALTH HISTORY FORM 1

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Camper Name: \_\_\_\_\_  
First Middle Last

Birth Date: \_\_\_\_\_  
Month/Day/Year

**General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.**

Has/does the camper:

- |   |   |
|---|---|
| 1. Ever been hospitalized? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                   | 11. Had fainting or dizziness? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                         |
| 2. Ever had surgery? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                         | 12. Passed out/had chest pain during exercise? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No         |
| 3. Have recurrent/chronic illnesses? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No         | 13. Had mononucleosis ("mono") during the past 12 months?... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No          | 14. If female, have problems with periods/menstruation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                      | 15. Have problems with falling asleep/sleepwalking? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| 6. Had asthma/wheezing/shortness of breath?..... <input type="checkbox"/> Yes <input type="checkbox"/> No   | 16. Ever had back/joint problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
| 7. Have diabetes? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                            | 17. Have a history of bedwetting?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
| 8. Had seizures? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                             | 18. Have problems with diarrhea/constipation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No           |
| 9. Had headaches? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                            | 19. Have any skin problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                             |
| 10. Wear glasses, contacts, or protective eyewear? <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Traveled outside the country in the past 9 months?..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |

**Please explain "Yes" answers in the space below,** noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

**Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.**

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? .....  Yes  No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?.....  Yes  No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?.....  Yes  No
4. Had a significant life event that continues to affect the camper's life?.....  Yes  No  
(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

**Please explain "Yes" answers in the space below,** noting the number of the questions. The camp may contact you for additional information.

**Health-Care Providers:**

Name of camper's primary doctor(s): \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
Name of dentist(s): \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
Name of orthodontist(s): \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

**What Have We Forgotten to Ask? Please provide in the space below** any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. **Attach additional information if needed.**

**Parents/Guardians: STOP here. The rest of this is form is completed when the camper arrives at camp. Keep a copy for your records.**