Horton Center Camper Health History for ADULTS (FORM 4)

*This is the only health form adult campers need

HORTON CENTER
ON PINE MOUNTAIN
A MINISTRY OF
THE NEW HAMPSHIRE CONFERENCE
UNITED CHURCH OF CHRIST

Dates attending camp: from _____ to _____
Camper Name: _____ Male Female Date of Birth _____
Camper Home Address:_____
Street Address City State Zip Code

Person to contact in case of emergency:
Name:_____Phone 1 (_____)_____
Relationship to Camper: _____Phone 2 (_____) _____
Email: _____
Address: _____(if different from above)

Allergies: Please list any known allergies, including, but not limited to food, medicines, and environmental agents:
(please describe below what you are allergic to and the reaction seen.)

Diet, Nutrition: (please circle) I eat a regular diet. I eat a regular vegetarian diet. I have special food needs
(Please describe below, continue on back if necessary)

I have reviewed the program and activities of the camp and feel I can participate without restrictions_____ (Initial)

I have reviewed the program and activities of the camp and feel I can participate with the following restrictions or adaptations _____ (Initial) **(Please describe, continue on back if necessary.)**

Medical Insurance Information: I am covered by 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. (_____)_____

Authorization for Health Care:
I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me, as may be necessary, including, but not limited to X.-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any re- cords necessary for treatment, referral, billing, or insurance purposes. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: I) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities. In the event I cannot communicate in an emergency, hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

_____ _____
Signature of Adult Camper Date
If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

☐ Check this box and use the other side of this sheet to record any additional information that camp staff should know, or should share with a doctor in the event you are unable to communicate