CAMP LEBANON

A MINISTRY OF AMERICAN BAPTIST CHURCHES OF NEW JERSEY
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Mr. Hilary Gierman
Site Manager of Camp Lebanon

Rev. Miriam Méndez
Executive Minister and Senior Regional Pastor

2025 HEALTH FORM
MUST BE COMPLETED IN FULL AND SIGNED BY PARENT/GUARDIAN

Camper's Name: _____
First Last

Camp Session: _____ ☐ Male ☐ Female

Birth Date: _____

Camper Home Address: _____
Street City State Zip

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

Name: _____ Relationship to Camper: _____
Preferred Phones: (_____) _____ (_____) _____
Email: _____
Home Address: _____
(If different from above) Street Address City State Zip

Second parent/guardian or other emergency contact:
Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship to Camper: _____
Preferred Phones: (_____) _____ (_____) _____
Email: _____
Home Address: _____
(If different from above) Street Address City State Zip

Medical Insurance Information:
I understand that this child must be covered by medical insurance to be accepted into the camp program at Camp Lebanon. ☐ Yes ☐ No

Insurance Company_____Policy Number_____

Name of Primary Insured _____Insurance Co. Phone Number(_____)_____

Primary Insured Date of Birth_____Relationship to Camper _____

Medication:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. Medication must be in original packaging/containers with labels.

Please list any medications the camper is to receive while at camp:

_____

_____

_____

Is this person in general good health and able to participate in normal activities? Yes _____ No _____
(If not, please submit a statement indicating limitations.)
Problems with: (check if YES)

_____ Hayfever _____ Fainting _____ Sulfa
_____ Bee Sting _____ Convulsions _____ Asthma
_____ Poison Ivy _____ Penicillin _____ Other
_____ Epilepsy (degree) _____

If any of the above are YES, please submit a statement of how the child has been treated and with what medication. Proper medicine must be brought to the camp and given to the nurse.

Please notify us if this child was exposed to any communicable disease during the three weeks prior to event.

Please write a note below to indicate any physical, emotional or psychological problem that will help the Nurse and Counselor provide the best possible experience.

All immunization will be the responsibility of the family in consultation with family physician or clinic. Give most recent date of Tetanus Booster. Then check the appropriate yes or no column to determine if camper has had necessary immunizations.

TETANUS BOOSTER (DATE REQUIRED)
most recent date received: _____

Received:	Yes	No	Received:	Yes	No
D.P.T. Series	___	___	D.P.T. Booster	___	___
Polio Series	___	___	Polio Booster	___	___
Mumps	___	___	Rubella Vac	___	___
Measles Vac	___	___			

Operation or serious injury and date(s)
_____
_____
_____
_____

If your camper has a religous exemption to immunizations, please provide a copy along with this form.

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

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

Allergies: ☐ No known allergies. ☐ This camper is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other (Please describe below what the camper is allergic to and the reaction seen.)

_____
_____

(Notes) _____
_____
_____

Parent/Guardian Authorization:
In signing this application, I hereby certify that the above health history is correct and accurately reflects the health status of the camper to whom it pertains. The camper 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.
Furthermore, I give permission for the use of photographs including my son or daughter in publicity; for my son or daughter to be transported in camp-owned and camp approved vehicles to and from public transportation or for approved out-of-camp activities.

Signature of Custodial
Parent/Guardian: _____ Date: _____ Relationship to Camper: _____