2024 Health History and Enrollment for Georgia Confederates Youth Camp Youth and Counselors

- Complete this form in ink answering all questions. Please print legibly
- The parent/guardian and camper both must sign this form.
- Mail to: GCYC, P.O. Box 447, Fitzgerald, Ga. 31750
- No one will be allowed to attend Georgia Confederates Youth Camp unless completed form is **received** by JUNE 17, 2024

Counselor's Full Name_____

Preferred Name_____

Address_____

The information on this form is gathered to assist the Georgia Confederates Youth Camp in identifying appropriate care. Health history must be filled out annually by parents/guardians of minors or by adults themselves who serve as camp volunteers, counselors.

Please check appropriate box: **[ ]** Camper (age 12-17) [ ] Volunteer/Counselor
Gender: **[ ]** M **[ ]** F [ ] Junior Counselor (18-20)

Camper's Full Name _____ Preferred Name _____

Birth Date _____ Age during Camp _____

Address_____
Street Address City State Zip

Custodial Parent or
Guardian_____

Home Address _____ Phone( )_____
Street Address City State Zip

Parent/Family e-mail_____ Mobile( )_____

Business _____ Phone( )_____
Name of Company Street Address City State Zip

Second Parent or Guardian_____

Home Address _____Phone( )_____
Street Address City State Zip

Parent/Family e-mail _____ Mobile( )_____

Business_____Phone( )_____
Name of Company Street Address City State Zip

If Parent(s) or Guardian not available in an emergency, notify:

Name _____ Relationship _____

Address _____Phone( )_____
Street Address City State Zip
Mobile( )_____

Insurance Information

Is the youth (counselor) covered by family health/medical/hospital insurance? [ ] Yes [ ] No

Health Insurance Carrier _____ Group/Policy No. _____

Health Insurance Address _____ Phone ( ) _____
Street Address City State Zip

Name of Insured _____ Relationship to camper _____

Physician/Dentist Information

Physician's Name _____ Phone ( ) _____
Street Address City State Zip

Dentist's Name _____ Phone ( ) _____
Street Address City State Zip

Allergies/Dietary Restrictions

List all known Allergies to medication, food, other (including insect stings, hay fever, penicillin, animal dander, plant allergies, etc.)

_____

Any medical or religious meal plan or dietary restriction: [ ] Yes [ ] No Explain: _____

_____

_____

Immunizations: Date of last Tetanus shot _____

List approximate date if participant has had or has been exposed to:

Chicken Pox _____ Tuberculosis _____ Measles _____

Are immunizations up-to-date: [ ] Yes [ ] No

My child has not had any immunizations due to parental religious beliefs and/or other beliefs [ ] Yes [ ] No

Medications
Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last entire time at camp. All prescription medications must be in original bottle, identifying prescribing physician (if a prescription drug), showing name of medication, dosage, and frequency of administration.

□ This person takes medications as follows:
Med #1 _____ Dosage _____Specific Time _____

Reason _____

Med #2 _____ Dosage _____Specific Time _____

Reason _____

Med #3 _____ Dosage _____Specific Time _____

Reason _____

□ This person takes NO medications on a routine basis.

Georgia Confederates Youth Camp is hereby granted permission to administer the following over-the-counter medications if the designated camp medical personnel deems it necessary. Dosages will be administered to directions on the bottle unless a physician directs otherwise.

Headache……Tylenol/Ibuprophen/Aleve……..…□ Yes □ No
Bites/Rashes……..……Antihistimine/(Benadryl/Claritin)……..……□ Yes □ No
Upset Stomach……Pepto Bismol/Tums/Rolaids……..…□ Yes □ No
Diarrhea……Immodium AD……..……□ Yes □ No
Menstrual Cramps……Ibuprophen or Aleve……..……□ Yes □ No
Poison Ivy……..Calamine Lotion or CortAid……..……□ Yes □ No
Ear Infection from Swimming……..Swim Ear–Rx……..……..□ Yes □ No
Coughing……Robitussin Cough Syrup……..……□ Yes □ No

.

General Health Height _____ Weight _____

Has/does the participant: [Explain "Yes" answers below]

1. Had any recent injury, illness or infectious diseases, Measles, mumps, mononucleosis? □ Yes □ No
2. Have a chronic or recurring illness or condition ear infections, heart condition? □ Yes □ No
3. Had any loss of consciousness, convulsion, Or concussion? □ Yes □ No
4. Have any medically prescribed meal plan or Dietary restrictions? □ Yes □ No
5. Have any bleeding or clotting? □ Yes □ No
6. Have hypertension? □ Yes □ No
7. Have hepatitis? □ Yes □ No
8. Have asthma? □ Yes □ No
9. Have epilepsy? □ Yes □ No
10. Have diabetes? □ Yes □ No
11. Had chicken pox? □ Yes □ No
12. If female, have an abnormal menstrual history? □ Yes □ No
13. Wear glasses, contacts or protective eye wear? □ Yes □ No
14. Currently under physician's care? □ Yes □ No

Explain any "yes" answers, noting the number of the question. _____

_____

_____

Check below if participant is subject to:

____Frequent Sore Throats
____Headaches
____ Fainting
____ Sleep Walking
____ Sinusitis
____ Frequent Colds
____ Convulsions
____ Kidney Trouble
____ Athlete's Foot
____ Diarrhea
____ Epileptic Seizures
____ Constipation
____ Heart Trouble
____ Bronchitis Cramps
____ Ear Infections
____ Home Sickness
____ Bed Wetting
Other – Specify_____

_____

_____

Mental, Emotional and Psychological Health
Has/does the participant:

1. Have an emotional health concern that will impact Camp participation? ……..□ Yes □ No
2. Have a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder? …….□ Yes □ No
3. Have a significant life event that continues to affect the camper's life/health?.....□ Yes □ No
4. Use an individualized learning plan at school?..... □ Yes □ No
5. Diagnosed or treated for Attention Deficit Disorder ……□ Yes □ No

Information about participant's physical, emotional, or mental health behavior, including sexual abuse, depression or suicide, of which the camp should be aware:

_____

_____

_____

Does the Participant have a Criminal/Juvenile Record or serious school disciplinary record? □ Yes □ No
If yes, please explain_____

_____

Health Examination by Licensed Medical Physician, Physicians Assistant or Certified Nurse Practitioner

Date of last examination:_____

The applicant is under the care of a physician for the following condition(s): _____

_____

Recommendations and Restrictions at Camp for Health Reasons

Description of any limitation or restriction on camp activities: _____

_____

Treatment to be continued at camp: _____

_____

Signature of Licensed Medical Personnel _____ Title _____

Doctor's Office/Clinic _____ Phone _____
Street Address City State Zip

- It is understood that all Georgia Confederates Youth Camp members in attendance will abide by the rules of the camp. If any member does not, the privileges of participating in the activities will be taken away; or in the case of a serious violation, the member will be returned home.
- By signing this form, I verify my child (camper) is at least 12 years of age.
- **This health history is complete and correct so far as I know, and the person herein described has permission to engage in all camp activities except as noted.**

Personal Release: I hereby irrevocably grant to Georgia Confederates Youth Camp the right to use, publish or distribute my and/or my child's image, name, voice and/or likeness, in whole or in part, for the purposes of promotion, education or marketing use by Georgia Confederates Youth Camp. I waive the right to inspect, approve or be compensated for the use to which it may be applied. I release Georgia Confederates Youth Camp for myself, my heirs, and executors, from all claims, demands or liabilities that may arise regarding the use of my and/or my child's image, name, voice or likeness. I have read and understand this Personal Release.

Emergency Authorization: I hereby give permission to the medical personnel selected by the Camp director to order x-rays, routine tests and treatment for me as a volunteer, counselor, staff or employee, or my child in the event I cannot be reached in an emergency. I herby give permission to the physician selected by the Camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child (or myself) as named above, if my child needs treatment for illness or injury which requires that he/she be taken from the camp to seek medical treatment. I understand that I will be notified immediately by the Camp director or designee.

I hereby agree 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; and (II) in the case of minors, to provide relevant information to the Camp representatives to keep me informed of my child's health status.

_____ _____ _____

Parent/Guardian Parent/Guardian Date

- I understand and agree to abide by the rules and restrictions placed on my camp activities _____
  Signature of Youth Member

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

PLEASE KEEP A COPY FOR YOUR RECORDS.

Mail completed form to:

GCYC
P.O. Box 447
Fitzgerald, Ga. 31750

Or eMail:
freedom308@windstream.net

For additional information or if you have questions, contact:

- Pastor John Weaver, Director: 229-425-0767or *freedom308@windstream.net*
- Hershell Smith at 229-425-5155 or hershellsmith1861@gmail.com
- Sonya Smith at 229-425-5155 or Sonyasmith474@gmail.com