**HEALTH DISCLOSURE Evans Creek Retreat** Birth Date \_\_\_\_\_\_\_\_ Gender\_\_\_\_

Full Legal Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Camp Name \_\_n/a\_\_\_\_\_\_\_\_\_

Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell/Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hair color \_\_\_\_\_\_\_\_ Eye Color \_\_\_\_\_\_\_\_ Height \_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_

Blood Pressure \_\_\_\_\_\_\_\_\_\_ Date Recorded \_\_\_\_\_\_\_ Date Last Tetanus Toxoid \_\_\_\_\_\_

Are all your immunizations current? \_\_\_\_\_\_\_ Date Last TB test\_\_\_\_\_ Result: Pos Neg

If from out of country please attach copy of immunization record.

Date of last physical \_\_\_\_\_\_ Physician/Clinic \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies (food, drug or other):** Describe reaction and medication or treatment needed.

Are you currently under the care of a physician, dentist/orthodontist or mental health care professional? Explain.

Please list past serious injuries/bone breaks or operations in the past:

Please list any conditions requiring hospitalization in the last five years:

Please indicate acute or chronic health issues (heart, asthma, bleeding disorders, diabetes, seizures, etc):

Please list any regular prescribed or emergency medications, vitamins or herbal supplement or regular non-prescription medication:

*Diet restrictions, food allergies or strong food preferences:*

**Emergency Contact** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Alternate Phone \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alternate Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing below, in the event of injury or illness, I grant the designated health care provider of Evans Creek Retreat to authorize/conduct care for myself or minor child as named above, as directed by the camp “Standing Orders”. If transportation to a medical facility is needed for appropriate care/treatment, I authorize Evans Creek to provide or to enlist appropriate transportation, including travel by ambulance if necessary. I further authorize Evans Creek Retreat to secure all mine/my minor child medications in a locked area and make those medications available at the appropriate time scheduled for administration.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of arrival at Camp: \_\_\_\_\_\_\_\_\_\_\_\_Temperature at arrival: \_\_\_\_\_\_\_\_\_\_\_ BP at arrival:\_\_\_\_\_\_\_\_\_\_ Symptoms or history at arrival, or previous 14 days:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(cough, muscle weakness, aches, vomiting, diarrhea, sore throat, fever, exposure to ill persons, travel out of country, etc.) (not mandatory) Covid Vaccine Type/Date Admin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Covid Test Results\_\_\_\_\_\_\_ on date of \_\_\_\_\_\_\_\_\_