



Whisper Mountain Ministries, Inc.
 Youth Camp • Wilderness Backpacking • Adult Retreat
 2240 Long Creek Road 828.479.2993 Website: www.WhisperMountain.org
 Robbinsville, NC 28771-8122 Email: info@WhisperMountain.org

WHISPER MOUNTAIN 2010 REGISTRATION & HEALTH FORM Date ___/___/___

The following information must be filled in by the parent/guardian, adult camper, staff member or volunteer. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to the camp upon participant's arrival at camp. Provide complete information so the camp can be aware of your need and emergency contact information.

PARTICIPANT INFORMATION T-shirt Size: Child M L Adult S M L XL 2X

Full Name _____ Birth date ___/___/___ Male Female
 Address _____ City/State _____ Zip _____
 Phone (____) _____ Email _____ Age During Camp _____ Grade _____

**MINOR PARTICIPANTS CUSTODIAL PARENTS/GUARDIAN INFORMATION
 OR ADULT PARTICIPANT INFORMATION**

Name _____	Name _____
Address _____	Address _____
City, ST, Zip _____	City, ST, Zip _____
Home Phone (____) _____	Home Phone (____) _____
Cell Phone (____) _____	Cell Phone (____) _____
Work Phone (____) _____	Work Phone (____) _____
Email _____	Email _____
Relationship to camper _____	Relationship to camper _____

If not available in an emergency, notify:
 Name _____ Home Phone (____) _____
 Address _____ Cell Phone (____) _____
 Relationship to participant _____ Work Phone (____) _____

PRIMARY INSURANCE INFORMATION

Is the participant is covered by Family/Medical/Hospital Insurance? Yes No
 Carrier or Plan Name: _____
 Group Name/Primary Insured: _____
 Policy Number _____
Attach photocopy of Health Insurance Card (Front & Back)

****PLEASE READ AND SIGN BELOW - MANDATORY FOR PARTICIPANT ATTENDANCE****

All information provided in the health history is correct and complete to my knowledge and the person herein described has permission to participate in all camp activities except as noted. I hereby give my permission to the camp or retreat leadership and/or camp staff to provide routine health care, administer prescribed medications, and seek emergency medical treatment including, but not limited to x-rays, routine tests and treatment and/or hospitalization. I give permission for the camp or retreat leadership and/or camp staff to arrange necessary related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp or retreat leadership and/or camp staff to secure and administer treatment, including hospitalization, for the person named above. This complete form may be photocopied for trips off campus from the Whisper Mountain camp property.

Parent and/or Guardian Signature: _____

Parent and/or Guardian Printed Name: _____

I hereby understand and agree to abide by any written or verbal restrictions placed on my participation in camp activities.

Participating Camper Signature: _____

ALLERGIES

- This Camper has **NO** known Allergies
- This Camper has Allergies as listed below

To Medications: (list) _____ To Foods: (list) _____

To Environment: (list) _____ EpiPen prescribed = Participant required to provide.
(Such as bee stings, hay fever)

Describe previous reactions: _____

MEDICATIONS

- This Camper takes **NO** Medications on a routine basis.
- This Camper takes the Medications listed below

Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Keep in original packaging/bottle that identifies the prescribing physician (if prescription), name of medication, dosage, and frequency of administration. *Please attach a separate sheet to list additional medications or specific instructions.*

Prescribing Physician Name: _____ **Physician Phone:** _____

Medication #1: _____ Reason for taking: _____

Dosage: _____ Time of day taken: _____

Medication #2: _____ Reason for taking: _____

Dosage: _____ Time of day taken: _____

DIET NUTRITION

- This Camper eats regular diet
- This Camper has medically prescribed dietary restriction and meal plan (attach or describe)

RESTRICTIONS

Please note any restrictions, limitations or adaptations that need to be made for participant in light of programs and facilities at camp. If participant has special accommodations at school, please attach a description.

GENERAL HEALTH QUESTIONS

Has or does the participant...

- | | | | |
|---|--|---|--|
| 1. Have any recent injury, illness or infectious disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Ever had back problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Have any chronic or recurring illness/conditions? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Ever had problems with joints (knees, ankles, etc)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Ever been hospitalized? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. An orthodontic appliance being brought to camp? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Ever had surgery? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Have any skin problems? (Itching, rash, acne, etc)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Have frequent headaches? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Have diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Ever had a head injury? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 21. Have asthma? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Ever been knocked unconscious? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 22. Had mononucleosis in the past 12 months? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Wear glasses, contacts, or protective eye wear? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 23. Had problems with sleepwalking? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Ever had frequent ear infections? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 24. If female, have abnormal menstrual history? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Ever passed out during or after exercise? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 25. Had problems with diarrhea/constipation? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Ever been dizzy during or after exercise? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 26. Have a history of bedwetting? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Ever had seizures? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 27. Had emotional difficulty which | |
| 13. Ever had chest pain during or after exercise? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Professional help was sought? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. Ever had high blood pressure? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 28 Ever had an eating disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15. Ever been diagnosed with a heart murmur? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Please explain any "yes" answers _____

Which of the following has the participant had?

- Measles Chicken Pox Mumps German Measles Hepatitis A Hepatitis B Hepatitis C

Immunizations: List Month/Year of most recent **Tetanus** ___/___

School Age Participants: Currently Enrolled in: Public School Private/Christian School Home School

Other School _____ Current Grade _____