HMBA Camp Ministry Team

Staff Medical Form

*Please Print Legibly. Please **Initial** or Circle Where Applicable.

_____________________________ Male / Female _________ _____/______/_______ (Name) (Gender) (Age) (Date of Birth)

EMERGENCY CONTACT INFORMATION

____
_ 1ST Contact Name Phone Relationship

____
_ 2nd Contact Name Phone Relationship

MEDICATIONS

If you have any presciption(s) *or* over-the-counter medication which needs to be dispensed during camp? **YES NO**
(If you answered "YES," please list below)

MEDICATION DOSAGE AMOUNT TO BE GIVEN TIME OF DAY 1.

2.

3.

4.

Please continue on a separate piece of paper, if needed.

MEDICAL HISTORY AND CONDITIONS

Date of last tetanus shot ___________________

Do you have any food allergies (if so, please list them out)

____
____

Do you have any medical allergies (if so, please list them out)

____
____

______ **All medications must be turned into the camp nurse (or other medical personel) at the time of registration. This includes all over-the-counter medications. NO medications are to be in the cabins.** Initial

______ **NO perscription medications will be given to any staff/volunteer by the camp nurse (or other medical personel) if it is not in it's original prescribed container. NO pre-filled/poured medications will be allowed.** Initial

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Staff Medical Form (cont.)

By signing below, I give my permission to the camp nurse (or other medical personel) to administer the checked over-the-counter medications to myself as they deem necessary:

___ All medications listed ___ Tylenol (liquid or tablets) ___ Ibuprofen (liquid or tablets)
___ Cough suppresant
___ Cold sore medication ___ Throat lozenges
___ Benadryl (liquid or tablets) ___ Ear drops (pain control)
___ Ear drops (swimmer's ear) ___ Anti-itch creams
___ Neosporin ointment ___ Tums
___ Pepto-Bismal
___ Acid control tabs
___ Orajel

X____ ___________________________________
(Signature) (Date)

By signing below, I give my permission to to the camp nurse (or other medical personel) to transport myself to SSM Health St. Mary's Hospital – Audrain – Emergency Room in Mexico, MO (573) 582-5000 for any medical emergency treatment needed.

I also give my permission to SSM Health St. Mary's Hospital – Audrain to provide emergency treatment to myself as deemed necessary by the attending physician(s).

X____ ___________________________________
(Signature) (Date)

INSURANCE

Insurance Company	Policy/Group #	Phone #

This information is in the event that the guardian cannot be contacted when a student is delivered to the Emergency Room.