



## HMBA Camp Ministry Team

### Student Medical Form

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

\_\_\_\_\_ Male / Female \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 (Camper Name) (Gender) (Age) (Date of Birth)

### EMERGENCY CONTACT INFORMATION

1 <sup>ST</sup> Contact Name	Phone	Relationship
2 <sup>nd</sup> Contact Name	Phone	Relationship

### MEDICATIONS

Does your child take prescription(s) *or* over-the-counter medication which need 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 \_\_\_\_\_

**Does your child have any:**

Allergies	Yes	No	Diabetes	Yes	No
Siezuers	Yes	No	Behavioral Issues	Yes	No
Bed Wetting	Yes	No	Other	Yes	No

*If you answered "YES" to any of the above, please explain:*

\_\_\_\_\_

\_\_\_\_\_ **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.**

\_\_\_\_\_ **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.**

**HMBA Camp Ministry Team**  
Student 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 my child as they deem necessary:

- |  |  |
|--|--|
| <input type="checkbox"/> All medications listed        | <input type="checkbox"/> Ear drops (swimmer's ear) |
| <input type="checkbox"/> Tylenol (liquid or tablets)   | <input type="checkbox"/> Anti-itch creams          |
| <input type="checkbox"/> Ibuprofen (liquid or tablets) | <input type="checkbox"/> Neosporin ointment        |
| <input type="checkbox"/> Cough suppressant             | <input type="checkbox"/> Tums                      |
| <input type="checkbox"/> Cold sore medication          | <input type="checkbox"/> Pepto-Bismal              |
| <input type="checkbox"/> Throat lozenges               | <input type="checkbox"/> Acid control tabs         |
| <input type="checkbox"/> Benadryl (liquid or tablets)  | <input type="checkbox"/> Orajel                    |
| <input type="checkbox"/> Ear drops (pain control)      |  |

X \_\_\_\_\_ (Guardian Signature) \_\_\_\_\_ (Date)

By signing below, I give my permission to to the camp nurse (or other medical personel) to transport my child 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 my child as deemed necessary by the attending physician(s).

X \_\_\_\_\_ (Guardian Signature) \_\_\_\_\_ (Date)

**\*Note: The parent or guardian will be notified of their child's need for emergency medical treatment before transport (if time permits). If not, they will be notified as soon as the child is in the E.R.**

<b>INSURANCE</b>		
_____	_____	_____
Insurance Company	Policy/Group #	Phone #
<i>This information is in the event that the guardian cannot be contacted when a student is delivered to the Emergency Room.</i>		