

# Concord Baptist Association Children's Camp Medical Release Form

Camper Name (First, Middle, Last): \_\_\_\_\_

Gender (circle one): Male/Female      Age: \_\_\_\_\_      Date of Birth: \_\_\_\_\_

Camper Home Address: \_\_\_\_\_

## Emergency Contacts:

1<sup>st</sup> Parent/Guardian Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Preferred phone(s): \_\_\_\_\_

2<sup>nd</sup> Parent/Guardian Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Preferred phone(s): \_\_\_\_\_

Additional contact in event parent(s)/guardian(s) cannot be reached:

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Preferred phone(s): \_\_\_\_\_

## Health History:

Allergies: please designate all that apply and use the space given to describe what the child is allergic to, and the reaction seen.

- No known allergies
- Food
- Medicine
- The environment (insect stings, hay fever, etc.)
- Other

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## Diet:

Does your child have any special dietary needs? If so, please describe.

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## Restrictions:

Does your child have any physical restrictions or require adaptations to participate in camp activities? If so, please describe.

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Medical Conditions:

Does your child have any serious/chronic medical conditions of which we should be aware? If so, please describe

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Medications:

Name of medication	Reason for taking it	When it is given	Amount or dose given	How it is given

The following non-prescription medications may be kept by the camp nurse and are used on an as needed basis to manage illness and injury. **Cross out those that your child should not be given.**

- |   |                          |
|---|--------------------------|
| Acetaminophen (Tylenol)                                   | Ibuprofen (Advil/Motrin) |
| Antihistamine/allergy medicine                            | Antibiotic cream         |
| Diphenhydramine antihistamine/allergy medicine (Benadryl) | Aloe                     |
| Calamine lotion   | Other _____              |

What Have We Forgotten to Ask? Please provide in the space below any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. Attach additional information if needed.

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By signing below, I give my permission to the camp nurse (or other medical personnel) to transport my child to the hospital for emergency medical treatment. I also give my permission to Lake Regional Hospital (Osage Beach) to provide emergency treatment to my child as deemed necessary by the attending physician(s).

Signature \_\_\_\_\_ (Date) \_\_\_\_\_

Healthcare Providers:

Name of camper's primary doctor: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name of dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Insurance Information: Please include a front/back copy of your insurance card

Insurance company: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Subscriber: \_\_\_\_\_ Insurance Co. Phone: \_\_\_\_\_