

JESUS IS LORD OF CAMP HOPE
MEDICAL HISTORY/PERMISSION TO TREAT

_____/_____/_____() M/F
Last name, First Name SSN DOB Age Sex Grade

Parent/Guardian Name Full Address (include zip code)

Home Phone Work/Cell Work/Cell

EMERGENCY CONTACTS TO ASSUME CARE OF CHILD IF PARENT UNAVAIL

1

Name relationship home/cell phone

2

Name relationship home/cell phone

Physician Name phone number

MEDICAL INSURANCE Company subscriber ID# (attach copy of card)

GENERAL HEALTH: List any conditions that may require ongoing care or special/emergency knowledge, meds or treatment: _____

ALLERGY/REACTION: List any to food, meds, animal, insect, etc: _____

For Severe Allergy, Asthma, Diabetes, etc, DOCTOR MUST COMPLETE PROTOCOL ORDERS and/or ALLERGY ACTION PLAN

List any medications used routinely: _____

PARENT & DOCTOR MUST COMPLETE MED PERMISSION FORM (1/child)

ACTIVITY PARTICIPATION: Please check approved & note exceptions:

- _____ Hiking & Camping _____
- _____ Water Activities _____
- _____ Competitive Sports _____
- _____ All Activities _____

Physician's Signature of Authorization that Child in Satisfactory health for Camp

Date (within 20__) It is okay to attach copy of Physical done in year 20__.

Height _____ Weight _____

IMMUNIZATIONS: I certify that my child has had all immunizations as required for school attendance. Yes ___ No ___ Date of Last tetanus _____
(Foreign Campers must submit full immunization record and current TB test results)

HISTORY OF: (Check if YES, and explain below)

- | | |
|---|--|
| Allergies _____ | Kidney/bladder problems _____ |
| Asthma _____ (doctor orders) | Lung/breathe problems _____ |
| Bedwetting _____ (parent info sheet) | Lyme disease _____ |
| Bleeding tendency _____ | Nasal/sinus problems _____ |
| Diabetes _____ (Doctor submit full regime) | Orthopedic problems _____ |
| Dental (braces, caps, etc) _____ | Rheumatic fever _____ |
| Eating Disorder _____ | Serious injury or Illness _____ |
| Epilepsy/convulsions ___ Last seizure _____ | Sleepwalking _____ |
| Fainting _____ | Speech problem _____ |
| Head Injury _____ (list restrictions below) | Stomach/bowel problems _____ |
| Hearing difficulty _____ | Vision problem ___ glasses ___ contacts ___ |
| Heart Disease _____ Describe | Other Med/surgical problem ___ List: |
| Hypertension _____ | Familial Medical problem ___ List: |
| Menstrual problem _____ | Mental/emotional/behavioral issues ___ List: |

AUTHORIZATION: (PARENTS: READ CAREFULLY BEFORE SIGNING)

I, the parent, have completed this history which, to the best of my knowledge, is complete and accurate. I understand that the medical information will be shared only with appropriate personnel on a need-to-know basis. I will secure and send doctor's orders for any condition or treatment or medication which my child routinely needs. I understand that I may not send a sick child, especially one who is contagious, to camp. I understand and authorize the Camp Nurses to administer medication or treatments according to Camp Hope Standing Orders or as prescribed by our Doctor or the local Camp Doctor, if needed by my child. I further hold the Camp Staff harmless in connection with the administration of medications and treatments. My child may participate in all camp activities unless noted specifically above. In the event that I cannot be reached in an emergency, I hereby give permission to the Camp Staff to secure treatment, hospitalization, injection, anesthesia or surgery for my child. I understand that I financially responsible for any/all medical bills/copays incurred, regardless of insurance. Some physicians may not accept my insurance, and I may be billed directly and have to submit the claim for reimbursement from my insurance. I attach a copy, front and back, of my child's insurance card.

Date _____ Signature of Parent/Guardian _____ Signature of individual if over 18yo _____

Camp session: Week 1 _____ or Week 2 _____ Both Weeks _____

ADDITIONAL NOTES: