

ACKNOWLEDGEMENT AND ASSURANCE

Our children are most precious to us. Our love for them cannot be overstated, nor our commitment to bringing them up "in the nurture and admonition of the Lord."

Those children who attend State Convention of Baptists events are entitled to the very best care by persons who will treat them in a Godly and compassionate manner.

By the signatures below, _____ Church acknowledges the importance of these values and goals, and further, assures the State Convention of Baptists that their church has taken prudent actions, including reasonable background inquiries, so as to be satisfied that each person identified below is suitable for volunteer ministries among children/youth.

For the safety of our children, no visitors will be allowed to attend any camp. Please note that any visitor showing up will be asked to leave. Visitors include anyone that is not registered for the event.

In addition, this form acknowledges that all chaperones will follow all camp rules or pastor will be contacted.

Please print names of church chaperones below.

The State Convention of Baptists assumes no liability for any negligent, wrongful and/or harmful acts of those identified above, or any others originating from the church who are attending State Convention sponsored events. The above church agrees to hold the State Convention of Baptists in Ohio harmless (including defense and indemnification) for any negligent, wrongful and/or harmful acts done by such individuals.

Pastor	Church Officer/Trustee
Home Phone	
Cell Phone	

****THIS FORM MUST BE SUBMITTED UPON REGISTRATION! SUBSEQUENT SUBMISSIONS OF VOLUNTEERS MAY BE MADE AT THE VERY LATEST, BY THE TIME OF REGISTRATION AT THE CAMP/EVENT.**

SENECA LAKE CAMP/RETREAT MEDICAL FORM

TO BE COMPLETED BY ALL ADULT PARTICIPANTS AND THE PARENT/GUARDIAN OF ALL UNDERAGE PARTICIPANTS.

NAME _____	DATE OF EVENT _____
BIRTH DATE _____	AGE _____ SEX (M/F) _____
PARENT/GUARDIAN _____	HOME & WORK PHONE (____) _____ / (____) _____
ADDRESS _____	CITY _____ STATE _____ ZIP _____
IN AN EMERGENCY NOTIFY _____	RELATION _____
HOME PHONE (____) _____	WORK PHONE (____) _____
CHURCH _____	CHURCH PHONE (____) _____

HEALTH HISTORY: (Check as applicable, giving approximate dates)

Frequent Colds _____	Stomach Upsets _____	Chickenpox _____	Sinusitis _____	Kidney Trouble _____
Measles _____	Ear Infection _____	Heart Trouble _____	German Measles _____	Bronchitis _____
Diabetes _____	Fainting _____	Tuberculosis _____	Whooping Cough _____	Rheumatic Fever _____
Convulsions _____	Epilepsy _____	Mumps _____		

Operations or Serious Injuries (list): _____

ALLERGIC REACTIONS: BEE STING _____ PENICILLIN _____ OTHER DRUGS _____
SERIOUS IVY / OAK OR SUMAC POISONING: _____

Details of above or additional information: _____

IN CASE OF MEDICAL EMERGENCY, I understand every effort will be made to contact parents/guardian of campers. In the event I cannot be reached, I hereby give my permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above. The camp provides accident medical coverage. This insurance is secondary to your, or your child's primary coverage, therefore, please provide your insurance carrier and the policy number.

Insurance Carrier: _____ Policy Number: _____

SIGNATURE _____ DATE: _____

PHOTOGRAPHY: Group and individual photos will be taken during camp. These may be used for promotional purposes and be displayed in the *Ohio Baptist Messenger* and SCBO website. Please initial this box if you do NOT wish your child's photos to be printed or appear online. To ensure this request is honored, please attach a photo to this form.

SWIMMING IN THE LAKE: Some youth groups may take the opportunity to go swimming in the lake at Seneca Lake State Park. Please check this box if you **do not** wish for your child to participate in this activity.

MEDICATION LISTING

For the safety of all concerned, it is the policy of Seneca Lake Baptist Assembly that ALL medication, other than special cases, be held and distributed through the First Aid Station by the nursing staff.

Over-the-counter medications are available in the First Aid Station. ONLY prescription medications need to be sent to camp. Medications must be brought to camp in the original container, with the correct dose, correct schedule, and correct person's name on the label.

Please list the name of the medication and the dose schedule below:

EXAMPLE:

MEDICATION	DOSAGE	TIMES	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Claritin	5 mg	nightly	10:00 pm	10:00 pm	10:00 pm	10:00 pm	10:00 pm
Prednisone	10 mg	2x daily	8:00 am	8:00 am	8:00 am	8:00 am	8:00 am
			4:00 pm	4:00 pm	4:00 pm	4:00 pm	4:00 pm

MEDICATION	DOSAGE	TIMES	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Please do not write below this line: _____

