CAMPUCAN 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)**______ **GRADE** _____ **T-SHIRT SIZE** ______**SHOE SIZE**________

PARENT/GUARDIAN ______________________________ **CELL PHONE (_______)**______________ _______

ADDRESS ______________________________ **CITY** ______________ **STATE** _____ **ZIP** __________

IN AN EMERGENCY NOTIFY ______________________________ **RELATIONSHIP** ______________

CELL 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 CampUCAN students. In the event I cannot be reached, I hereby give my permission to the physician selected by the CampUCAN Director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above. CampUCAN 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. ***Please attach a copy of your insurance card to this form.***

Insurance Carrier: ______________________________ Policy Number: ______________________________

SIGNATURE ______________________________ DATE: ______________________________

MEDICATIONS FOR: ______________________________ ______________________________

Name **Church**

For the safety of all concerned, it is the policy of CampUCAN 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

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

Please do not write below this line: ______________________________