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: ______________________

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☐ **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.

☐ **The Camp nurse** does not have permission to administer Tylenol, Ibuprofen, and/or an over-the-counter antihistamine as needed. Permission will be assumed unless marked.

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

MEDICATION	DOSAGE	TIMES	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY

Please do not write below this line: