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)** **GRADE** ________ **T-SHIRT SIZE** ________

PARENT/GUARDIAN ______________________ **HOME & WORK PHONE** (____) ___________ / (____) ___________

ADDRESS ______________________ **CITY** ______________ **STATE** ______ **ZIP** ________

IN AN EMERGENCY NOTIFY ______________________ **RELATION** _ ___________

HOME PHONE (____) ______________ **WORK PHONE** (____) ______________ **EMAIL** ______________________

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. ***Please attach a copy of your insurance card to this form.***

Insurance Carrier: ______________________ Policy Number: ______________________

SIGNATURE ______________________________ DATE: ______________________

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

MEDICATIONS FOR: ______________________________ ______________________________

Name *Church*

For the safety of all concerned, it is the policy of SCBO 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:

MEDICATIONS	DOSAGE	TIMES	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY

Please do not write below this line: