HOPE SHORES BIBLE CAMP HEALTH RECORD & RELEASE FORM - 2018

NAME: _____ Date of Birth _____
Last First M.I.

Sex: M F Social Security # _____ Age _____

Address: _____ Phone # _____

City _____ State _____ Zip _____ County _____

PARENT INFO

Parent(s): _____ Phone #: _____

Address: _____ Work Phone # _____

City _____ State _____ Zip _____

Parental Employer: _____

Emergency Notification Name: _____ Relationship: _____
(other than parent)

Address: _____ Phone #: _____

MEDICAL INSURANCE

Medical Assistance ☐ Yes ☐ No Medical Assistance #: _____

Is health insurance carried through parental employer?

FATHER: ☐ Yes ☐ No MOTHER: ☐ Yes ☐ No

PLEASE ATTACH A COPY OF YOUR HEALTH INSURANCE CARD (HOSPITALS PREFER THIS TO ANYTHING ELSE) – CARDS WILL NOT BE COPIED AT CHECK IN

Family Doctor: _____ Phone #: _____

PARENT'S AUTHORIZATION

I hereby release Hope Presbyterian Church, its staff and sponsors, from responsibility and liability for any injury or illness that my child may sustain at camp. In the event of an emergency, I hereby authorize an adult leader, as agent for me, to consent to an X-ray examination, medical or surgical diagnosis, treatment or hospital care advised and supervised by a physician, surgeon or dentist (as appropriate) licensed to practice under the laws of the state where the services are rendered, either at a doctor's office or in any hospital. I expect to be contacted as soon as possible. **I permit the camp nurse to dispense the following medications if necessary: Sudafed, Benadryl, Ibuprofen, and Tylenol.**

Signature of Parent or Legal Guardian _____ Date _____

Medications: Hope Shores Bible Camp carries general over the counter medications in the infirmary, such as Tylenol, cold medicines, Benadryl etc. Please do not feel you need to send these with your child unless they are needed on a regular basis. It is required to send all prescription medications in their ORIGINAL container (with name, dose, frequency clearly written) in order to have our nurse safely administer them. The nurse collects all medications from the campers. They will be handed out as prescribed.

(over)

Part II (To be filled out by Physician)

State law requires an immunization record giving dates indicating that the camper is fully protected from the included diseases. This form must be reviewed by a doctor with in 90 days of admission to camp.

Name: _____ Sex: M F

Height:_____ Weight_____ BP_____Pulse_____

Review of Systems:

Skin & Nails _____Abdomen_____ HEENT_____ Genitalia _____

Neck _____Musculoskeleta_____ Cardiovascular_____Neuro_____

Respiratory_____ Lymphatics _____

Restrictions (if any): _____

_____

Any evidence of contagious disease? Yes ☐ No ☐ If yes, please advise._____

_____

Other:_____ Allergies: _____

_____

I have made the necessary tests to determine the health condition of this person and find him/her fit to participate in camp activities.

SIGNATURE OF PHYSICIAN _____ Date _____

Part III (To be filled in by parent or guardian)

Date of most recent immunization against:

Polio: _____ DPT _____ MMR_____ Hepatitis B_____

Has the camper been exposed to any of the following recently:

❑Strep Throat ❑ Chicken Pox ❑ Tuberculosis ❑ Measles

Does the camper have difficulties with any of the following?

❑ Appendicitis ❑ Allergies ❑Asthma ❑Appendix Removal ❑Diabetes

❑Fainting ❑Heart trouble ❑Convulsions/Epilepsy ❑Kidney ❑ Nosebleeds

❑Sore throats ❑Colds ❑Headaches ❑Bed wetting ❑Constipation

❑Sleepwalking ❑Eating /foods

Does the camper have any **drug or food** allergies? _____

MEDICATIONS

NAME of Medication (in original container)	DOSAGE	TIMES	REASON GIVEN