2022 SUMMIT CAMP MEDICAL RELEASE

Please fill this form out as completely as possible for us to be able to provide the best care to your child while they are at camp. Every camper needs a completed health form to participate in any SUMMIT CAMP activities.

SECTION I - BASIC CONTACT INFORMATION

Name: _____ **Birthdate**:___/___/_____ **Age**:_____

Home Address: _____
Street City State ZIP

Social Security #: _____ **Gender**: M F

Camper Lives With: Mother & Father Mother Father Grandparent Other _____

Custodial Parent/Guardian: _____ Phone: ( )_____

Home Address: (if different) _____
Street City State ZIP

If not available in an emergency, please notify: _____

Relationship: _____ **Phone**: ( )_____

Family Physician Name _____ **Phone**: ( )_____

Dentist/Orthodontist Name _____ **Phone**: ( )_____

SECTION II - TRANSPORTATION

In order to protect your child, please provide us with the following information:

Who will be picking your child up at Parchment Valley at the close of camp?
Name: _____

Is there anyone whom you do not want to pick up your child at the close of camp? If yes, please list name(s) _____

SECTION III - INSURANCE INFORMATION : Please include a copy of your insurance card and fill out the information below in the event of needing prompt health care for your child.

Is the participant covered by family medical/hospital insurance: YES NO

If so, indicate carrier or plan name: _____ Group # _____

Carrier Address: _____

Address for Claims: _____

Policy Holder's Name: _____ Relationship: _____

Policy Holder's Insurance ID #: _____ Employer: _____

Policy Holder's Social Security #: _____ Policy Holder's Date of Birth: ____/____/____

SECTION IV - ALLERGIES

☐ Camper does not have any allergies.

Camper is allergic to:

☐ Hay Fever ☐ Poison Ivy/Oak ☐ Insect Stings ☐ Certain Foods

☐ Penicillin ☐ Other Drugs: _____

Please specify allergy and describe reaction and treatment.

_____

_____

SECTION V - MEDICATIONS AND RESTRICTIONS

Will camper be taking medications while at camp? Yes No

***Medications include prescription, over-the-counter, vitamins, inhalers, etc.*

If camper will be taking medications while at camp, please list all (prescription and non-prescription). Include the medication name, prescribing physician, physicians' phone number, and the dosage instructions. Use an additional sheet if needed. When checking in at camp, please provide all medications in their original packaging that identifies the prescribing physician (if prescription drug), the name of the medication, the dosage, and frequency of administration.

NAME OF DRUG	DOSAGE AMOUNT	TIMES GIVEN	DAILY DOSE	REASON FOR MEDICATION	NOTES:
Example: Mellaril	50 mg	8 am & 5 pm	100 mg	Behavioral	Crush pill

Identify any medications the camper takes during the school year that the camper does not/may not take during the summer: _____

Prescribing Physician: _____ Phone: ( )_____

I grant permission for the camp health director to administer:

***Please circle your choice for each over-the-counter medicine below*

Aspirin Yes No **Non-Aspirin** Yes No **NSAID** (ibuprofen/Advil, Motrin) Yes No

Cough Medicine Yes No **Benadryl** Yes No **Pepto-Bismol** Yes No

Maalox Yes No **Imodium** Yes No

Parent/Guardian Signature for over-the-counter administration _____

Special Instructions or Considerations for Minor Illness *Please provide information (past and present) on any illnesses, injuries (i.e. broken bones, concussions, asthma, etc.) or special instructions for minor illnesses. Unless specific instructions are provided, camp health care staff will treat minor illnesses with over the counter medications. If illness persists, parents will be notified.*

_____

_____

Has your child ever been put in concussion protocol? Yes No If so, when? _____

Any change to this form should be provided to camp health personnel upon camper's arrival in camp.

SECTION VI - AUTHORIZATION

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp. I understand that all reasonable attempts will be made to contact me as soon as possible after the condition necessitating treatment arises, and, that failing to reach me, all reasonable attempts to contact the alternate listed above will be made. I understand that all reasonable precautions will be taken for safety at all times. I further release the West Virginia Convention of Southern Baptists, the Camp Cowen Board, the Parchment Valley Board of Directors, the West Virginia American Baptist Youth, and all persons associated with these organizations from any liability associated with any accident, injury or disease to the person who is the subject of this form.

_____ _____

SIGNATURE OF PARENT/GUARDIAN OR ADULT CAMPER/STAFFER **DATE**

_____

PRINT FULL NAME

SECTION VII - NOTARY

STATE OF WEST VIRGINIA County of, _____ ,
_____ to wit: I, a qualified Notary Public, in and for the County aforesaid, hereby certify that the person whose signature appears above, did on this date, appear before me, after begin duly sworn or affirmed, and reading this document in its entirety did affix his or her signature hereto in my presence.

_____ NOTARY PUBLIC

Date Executed: _____/_____/_____ My Commission Expires: _____/_____/_____

***Notary stamp applied below*