

<i>For Office Use Only</i>		Date:	
Q #1		Q #3	
Q #2		Q #4	
Ob. Of Ind.		HCBC Staff Init.	

CONFIDENTIAL MEDICAL INFORMATION FORM

Camper Staff

Effective 3/23/10

The following information is not part of the camper or staff acceptance process, but is gathered only to assist in identifying appropriate care.

Full Name of Camper/Staff Member: _____

Camp Session: _____ Date of Birth: _____

List any conditions requiring restrictions from activities or other considerations while at camp. Please give full details and initial below (use back for more details): _____

Initials: _____

If no restrictions, parent/guardian/adult, please initial here: _____

Please list all current medications being taken and reason for taking them: _____

(NOTE: All medications for campers must be turned over to Camp medical personnel during on-site camp check-in and ALL MEDICATIONS MUST BE IN THE ORIGINAL CONTAINER FROM PHARMACY.)

Record of Past Medical Treatment: *(Indicate approximate date)*

Frequent Problems or Disease

- ___ Frequent Ear Infections
- ___ Frequent Headaches
- ___ Frequent Sore Throat
- ___ Heart Defect/Disease
- ___ Bedwetting
- ___ Sleepwalking
- ___ Bleeding/Clotting
- ___ Seizures
- ___ Diabetes
- ___ Asthma
- ___ Other

Allergies

- ___ Hay Fever
- ___ Ivy Poisoning
- ___ Insect Stings
- ___ Chlorine
- ___ Drugs _____
- ___ Food _____
- ___ Other: _____

Immunizations

Immunizations up to date for school?
 Yes _____ No _____
 Date of last Tetanus shot: _____

Operations or serious injuries (dates): _____

Other Chronic or recurring illness or medical condition: _____

Dietary restriction: _____

Name of Family Physician or Health Care Facility: _____ Phone: _____

Date of most recent physical exam: _____ (American Camping Association requires exam date to be within 24 months of camp session.)

Emergency Contact: _____ Phone: _____

Alternate Contact: _____ Phone: _____

Insurance: Do you carry medical/hospital insurance? ___Yes___No

If so, indicate Carrier: _____ Policy Number: _____

The camper, volunteer and/or parent/guardian are responsible for all bills for medical treatments incurred while participating in the Camp program at Hickory Cove Bible Camp.

IMPORTANT: THIS BOX MUST BE READ AND COMPLETED FOR ATTENDANCE

AUTHORIZATION FOR TREATMENT:

By my signature below, I hereby give permission to the medical personnel selected by the Camp Administration to order X-rays, routine tests, and treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for the above-named camper. In the event I cannot be reached in an emergency or am otherwise unable to communicate with Camp authorities, I hereby give permission to the physician selected by the Camp Administration to secure and administer treatment, including hospitalization, for the camper named above. This completed form may be photocopied. I hereby give permission for the information listed above, as well as any information concerning injury, illness, medical history, consultation, prescription, treatment or policy coverage for and about this camper, to be shared with necessary Camp personnel, outside medical personnel, pharmacists, and appropriate insurance company representatives, at the sole discretion of Hickory Cove Bible Camp, its staff and volunteers. I affirm that the above information is correct to the best of my knowledge, and I understand that it is my responsibility to update any and all information on this form if it changes between now and the start of my child's camp session.

Signature of adult Camper/Staff: _____ Date: _____

Signature of Parent or Guardian of minor Camper/Staff: _____ Date: _____