

Seneca Lake Baptist Assembly Medical Form

TO BE COMPLETED BY ALL ADULT PARTICIPANTS AND PARENT/GUARDIAN FOR ALL UNDERAGE PARTICIPANTS
TO BE GIVEN TO CAMP NURSE DURING ON-SITE REGISTRATION

NAME _____ DATE OF EVENT _____

BIRTH DATE _____ AGE _____ GENDER: _____ MALE _____ FEMALE

PARENT/GUARDIAN _____ CELL PHONE (_____) _____ - _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMERGENCY CONTACT _____ RELATION _____

EMERGENCY CONTACT CELL PHONE (_____) _____ - _____ WORK PHONE (_____) _____ - _____

CHURCH _____ CHURCH PHONE (_____) _____ - _____

HEALTH HISTORY (check as applicable/give approximate dates)

_____ Frequent Colds	_____ Stomach Upset	_____ Chickenpox	_____ Sinusitis	_____ Kidney Trouble
_____ Measles	_____ Ear Infection	_____ Heart Trouble	_____ Bronchitis	_____ German Measles
_____ Diabetes	_____ Fainting	_____ Tuberculosis	_____ Mumps	_____ Whooping Cough
_____ Rheumatic Fever	_____ Convulsions	_____ Epilepsy	_____ Covid 19	

Operations or Serious Injuries (list) _____

ALLERGIC REACTIONS: _____ Bee Sting _____ Penicillin _____ Other Drugs _____ Serious Ivy / Oak or Sumac Poisoning

Details Of Above/Additional Information _____

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*, KK Facebook Page and SCBO website. **Please initial this box if you do NOT wish your child's photo/video to be printed or appear online.** To ensure this request is honored, **please attach a photo to this form.**

IN CASE OF AN EMERGENCY, I understand that every effort will be made to contact the parents/guardian of the camper. 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 yours or your child's primary coverage. Therefore, please provide your insurance carrier and policy number. Please attach a copy of your insurance card to this form.

Insurance Carrier _____

Policy Number _____

Signature _____

Date _____

COVID SYMPTOMS PROCEDURE: Parents will be notified immediately if their child develops symptoms of Covid 19. Symptoms include cough (if chronic cough, change from their baseline), difficulty breathing (not due to asthma), diarrhea, vomiting, new onset of severe headache, temperature 100.4 F and higher, and/or sore throat.

MEDICAL 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: _____