

SENECA LAKE 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) _____	
PARENT/GUARDIAN _____	HOME & WORK PHONE (_____) / (_____) _____		
ADDRESS _____	CITY _____	STATE _____	ZIP _____
IN AN EMERGENCY NOTIFY _____		RELATION _____	
HOME PHONE (_____) _____	WORK PHONE (_____) _____		
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.

Insurance Carrier: _____ Policy Number: _____

SIGNATURE _____ DATE: _____

1

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

The Camp nurse does not have permission to administer Tylenol, Ibuprofen, and/or an over-the-counter antihistamine as needed. Permission will be assumed unless marked.

MEDICATION 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: _____