SUPER SUMMER 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)**_____ **GRADE** _____ **T-SHIRT SIZE** _____

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

ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP** _____

IN AN EMERGENCY NOTIFY _____ **RELATION** _____

CELL 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 Super Summer students. In the event I cannot be reached, I hereby give my permission to the physician selected by the Super Summer Director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above. Super Summer 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. ***Please attach a copy of your insurance card to this form.***

Insurance Carrier: _____ Policy Number: _____

SIGNATURE _____ DATE: _____

☐ **PHOTOGRAPHY:** Group and individual photos/video will be taken during Super Summer. These may be used for promotional purposes and be displayed in the *Ohio Baptist Messenger*, Super Summer Facebook Page and the 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 of the individual that should not be photographed/recorded to this form for our reference.

MEDICATIONS FOR: _____ _____

Name **Church**

For the safety of all concerned, it is the policy of Super Summer 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: