Cabin_____

FAMILY CAMP
EMERGENCY MEDICAL AUTHORIZATION AND INFORMATION
(Please complete both sides of this form)

Camper's Name: Last_____ First_____ MI_____
Address:_____City:_____State: _____Zip:_____
Date of Birth_____ Age:_____ Sex: ____M ____F Social Security No:_____

Parent or Legal Guardian Name (s): Dad: Last_____First_____
Dad's Phone Numbers: Home: _____ Cell:_____ Work:_____
Mom: Last_____First_____
Mom's Phone Numbers: Home:_____ Cell: _____Work:_____

Emergency Contact, if parents cannot be reached:
Name:_____(Relationship to Camper)_____Contact Phone:_____

Medical Insurance Company_____
Policy Number:_____ Contract #_____Group #_____
(Please attach photocopy of your Insurance Card)

MEDICATIONS

Due to Federal and State law ALL medications must be in their original bottles and be in the name of the camper taking the medication! All prescription medication must have the prescription label. If you have an inhaler, the box must come with it. **We CAN NOT give the prescription medication without the label.** If the dose or times have changed from the label on the bottle, we must have an authorized note with the changes on it.

Clare United Methodist Family camp maintains a supply of commonly used over-the-counter (OTC) medications for first aid treatment. There is no need to send a bottle of Tylenol, Advil, Cough drops, Benadryl, and Band-Aids, etc. However, if your child can only have a specific brand due to allergies or toleration to medications, we highly recommend that you send them. This would include vitamins.

Our camp medical personnel are allowed to administer OTC medications to your child at camp. If yes, please initial_____.

****ALL MEDICINE MUST BE IN THEIR ORIGINAL CONTAINERS.****
(Continue any additional meds on back of this sheet)

Please list any and all medications your child needs to take at camp:

Name of Medication	Dose	Reason for Medication	Time(s) Taken

HEALTH HISTORY

(Continue any additional information on the back of this sheet)

Please "X" all that apply:

_____Convulsions or Seizures
_____Frequent Ear Infections
_____Heart Trouble
_____Headaches
_____Migraines
_____Sleepwalking
_____Bedwetting

_____Bleeding or Clotting Disorders
_____Trouble with passing urine
_____ Difficulty with bowel movements
_____ Asthma
_____ Wheezing
_____ Behavioral Disorders
_____ Emotional Disorders

____If female:
Knows about menstruation?
_____Yes _____No
Started Menstruating?
_____Yes ____No
Menstrual Problems?
_____Yes _____No

Allergies:

_____Food (please list) _____
_____Animals (please list)_____
_____ Bee Stings – Treat with _____
_____Poison Ivy _____Environmental _____ Seasonal/Hay Fever

Medication Allergies (please list)

_____, _____, _____, _____

Other potential health problems or restricted activities: _____

_____

Please list any other potential health or behavioral problems: _____

_____

Immunization History:

Immunization up to date according to state requirements for age: _____Yes _____No
Date of last Tetanus Booster: _____

Head lice check: _____ (Initials of examiner that found camper to be clear)

REQUIRED OF EACH YOUTH CAMPER: (Please initial each statement and sign at the bottom)

_____I HEREBY GIVE PERMISSION TO THE CLARE UNITED METHODIST FAMILY CAMP TO SECURE EMERGENCY MEDICAL TREATMENT AND SURGICAL TREATMENT. PERMISSION IS ALSO GIVEN TO PROVIDE ROUTINE, NON-SURGICAL CARE FOR THE MINOR CHILD LISTED ABOVE WHILE ATTENDING THIS CAMP.

_____I RELEASE ALL PHOTOS, VIDEO, AND AUDIO TAPES OF MY CHILD FOR INFORMATIONAL AND PROMOTIONAL PURPOSES SUCH AS BROCHURES, DAILY WEB AND FACEBOOK UPDATES, ETC.

_____I CERTIFY THAT ALL THE INFORMATION ON THIS SHEET IS TRUE TO THE BEST OF MY KNOWLEDGE.

_____ _____

Parent or legal guardian signature Date

ANY ADDITIONAL INFORMATION: (Attach a separate page if needed)