



Medical History Form

Year in attendance: _____

Camper's Full Name: _____ Date of Birth _____ Age: _____

Parent/Guardian Name: _____ Male Female

Phone: _____ Emergency Phone: _____ Cell: _____

Address: _____ City/State/Zip: _____

To save time, in case of an emergency, please list your insurance company and policy number, if any.

Insurance Co: _____ Policy #: _____

Year of most recent (DTP) Tetanus Booster _____

Family Doctor: _____ Phone#: _____

Address: _____

HEALTH ISSUES (Check all that apply.)

Diabetes Epilepsy Bed Wetting Fainting Sleep Walking Other, please specify: _____

Behavior Problems, please specify: _____

Any other special needs (Dietary, etc...): _____

CAMPER IS ALLERGIC TO: (Check all categories that apply, and list specifics.)

Medications: _____

Foods: _____

Other (Bees, latex, iodine, etc.): _____

Allergy Medicine (please provide to nurse): _____

Yes No

Permission to Treat Camper

I hereby give my permission for the nurse to administer the following prescription medication to my child. List medications camper is on and what taken for: _____

Note: ALL prescription medication MUST be administered by Nurse and kept in ORIGINAL container, labeled with Patient's Name, Description, Dosage, Time Taken, expiration date, and Doctor's name.

I hereby give my permission for the nurse to administer the following over-the-counter / non-prescription medication as needed:

<input type="checkbox"/> Tylenol (Acetamethaphin)	<input type="checkbox"/> Advil / Motrin (Ibuprofen)	<input type="checkbox"/> Claritin (Antihistamine)
<input type="checkbox"/> Zyrtec (Antihistamine)	<input type="checkbox"/> Cough drops (lozenge)	<input type="checkbox"/> Tums (Antacid)
<input type="checkbox"/> Midol	<input type="checkbox"/> Peptobismal (anti-nausea, anti-diuretic)	
<input type="checkbox"/> Caffeine (ages 12+ in coffee format only)		

I hereby certify that my child has not been exposed to or is exhibiting symptoms of any communicable or contagious conditions. I further agree that should my child exhibit such symptoms I will be responsible to retrieve them at my own expense.

In case of a medical emergency, I understand every effort will be made to contact parents or guardians. In the event I cannot be reached, I hereby give my permission to the licensed physician selected by the camp directors to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above.

Note: This must be checked "Yes" for your child to attend camp.

Parent/Guardian Signature

Date

*More Medical forms can be found on our website:
www.thenorthlandbiblecamp.com*

NorthLand Bible Camp
24304 Flint Ave., Tomah WI 54660
(608-387-5199)
Biblecamp.northland@gmail.com



Camp Notes:

Initial / Date _____