Camp Session: _____ **Year:** _____

WEST VIRGINIA BAPTIST CAMP AT COWEN
PERMISSION FOR EMERGENCY TREATMENT & HEALTH HISTORY

Please fill this form out as completely as possible for us to be able to provide the best care to your child while they are at camp.
Every camper needs a completed health form to participate in any Cowen summer camp programs.

SECTION I – BASIC CONTACT INFORMATION

Name _____ Birthdate_____ Age at Camp _____
Last First Middle

Home Address _____
Street Address City State ZIP Code

Social Security Number of participant _____ Gender: ☐ M ☐ F

Camper Lives With: oMother & Father oMother oFather oGrandparent oOther: _____

Custodial Parent/Guardian _____ Phone _____

Home Address _____
(If different from above) Street Address City State ZIP Code

Home Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____

If not available in an emergency, notify _____

Relationship _____ Phone _____

Address _____
Street Address City State ZIP Code

Family Physician Name _____ Phone_____

Dentist/Orthodontist Name _____ Phone_____

SECTION II – TRANSPORTATION

In order to protect your child, please provide us with the following information:

Who will be picking up your child at the West Virginia Baptist Camp at Cowen at the close of camp?

Name: _____

Is there anyone in particular you do not want to pick up your child at the close of camp? If yes, please list the name(s) below:

Name: _____

Name: _____

SECTION III – NOTARY

STATE OF WEST VIRGINIA

County of, _____, _____ to wit:
I, a qualified Notary Public, in and for the County aforesaid, hereby certify that the person whose signature appears above, did on this date, appear before me, after begin duly sworn or affirmed, and reading this document in its entirety did affix his or her signature hereto in my presence.

_____ NOTARY PUBLIC Date Executed_____

My Commission Expires:_____ Please imprint seal in the area to the right:

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp. I understand that all reasonable attempts will be made to contact me as soon as possible after the condition necessitating treatment arises, and, that failing to reach me, all reasonable attempts to contact the alternate listed above will be made. I understand that all reasonable precautions will be taken for safety at all times. I further release the West Virginia Baptist Convention, the Camp Cowen Board, the Parchment Valley Board of Directors, the West Virginia American Baptist Youth, and all persons associated with these organizations from any liability associated with any accident, injury or disease to the person who is the subject of this form.

SIGNATURE OF PARENT/GUARDIAN OR ADULT CAMPER/STAFFER_____

THANK YOU FOR HELPING US PROTECT YOUR CHILD.
Please fill in the information on the reverse side of this form.

SECTION IV – INSURANCE INFORMATION – Please include a copy of your insurance card.

Please fill out the below information in the event of needing prompt health care for your child.

Report any changes to this form at registration

Is the participant covered by family medical/hospital insurance: ☐ YES ☐ NO

If so, indicate carrier or plan name: _____Group # _____

Carrier Address: _____

Address for Claims: _____

Policy Holder's Name: _____ Relationship to Participant: _____

Policy Holder's Insurance ID Number: _____ Employer: _____

Policy Holder's Social Security Number: _____ Policy Holder's Date of Birth: ____/____/_____

SECTION V – ALLERGIES

☐ Camper does not have any allergies

Camper is allergic to: ☐ Poison Ivy/Oak ☐ Insect Stings ☐ Medications: _____ ☐ Food Allergy: _____

Reactions: _____

SECTION VI – MEDICAL HISTORY AND MEDICATIONS

Medical History:

Check "Yes" or "No" for each statement. Explain "Yes" answers below. Has/does the camper:

1. Had a recent hospitalization/surgery?	☐ YES ☐ NO	7. Had seizures?	☐ YES ☐ NO
2. Had a recent illness?	☐ YES ☐ NO	8. Had severe headaches?	☐ YES ☐ NO
3. Had a recent injury?	☐ YES ☐ NO	9. Wear glasses, contacts, or protective eyewear?	☐ YES ☐ NO
4. Have recurrent/chronic illnesses?	☐ YES ☐ NO	10. Had fainting or dizziness?	☐ YES ☐ NO
5. Had asthma/wheezing/shortness of breath?	☐ YES ☐ NO	11. Passed out/had chest pain during exercise?	☐ YES ☐ NO
6. Have diabetes?	☐ YES ☐ NO	12. Traveled outside the country in the past 9 months?	☐ YES ☐ NO

13. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ☐ YES ☐ NO

14. Ever been treated for emotional or behavioral difficulties or an eating disorder? ☐ YES ☐ NO

15. Seen a professional to address mental/emotional health concerns in the last 12 months? ☐ YES ☐ NO

16. Had a significant life event that continues to affect the camper's life? (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, etc.) ☐ YES ☐ NO

17. Been on concussion protocol? (If so, when?) ☐ YES ☐ NO

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

_____

_____

**** Child under 18:** Should your camper need immediate medical attention outside of camp, hospital emergency staff as well as paramedics need to know your child's **Height:_____ft ____in Weight: _____** to provide proper treatment in your absence.

Will the camper be taking medications while at camp? ☐ YES ☐ NO

ALL MEDICATIONS MUST BE TURNED IN to the medical personnel at registration. (INCLUDING prescription, over the counter, inhalers) Please list all (prescription and non-prescription). Include the medication name, dosage, and dosage instructions. Use an additional sheet if needed. Bring to camp all medications in their original packaging that identifies the prescribing physician, the name of the medication, the dosage and the frequency of administration.

NAME OF DRUG	DOSAGE AMT.	TIMES GIVEN	TOTAL DAILY DOSE	REASON FOR MEDICATION	SPECIAL INSTRUCTIONS

Prescribing Physician: _____ Phone Number: _____

Identify any medications the camper takes during the school year that the camper does not/may not take during the summer:

_____

_____

I grant permission for the camp health personnel to administer over-the-counter medications indicated below:

Tylenol	yes no	Motrin/Advil	yes no	Pepto-Bismol	yes no	Maalox/Tums	yes no
Imodium	yes no	Benadryl	yes no	Cough Medicine	yes no	Allergy Relief/Claritin	yes no

Parent signature for over the counter administration: _____