

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

Gender: M F

Custodial Parent/Guardian: _____

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 – AUTHORIZING SIGNATURE AND NOTARY

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: _____

STATE OF WEST VIRGINIA

County of, _____,

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 being 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:

SECTION III – 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.

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: ____/____/____

THANK YOU FOR HELPING US PROTECT YOUR CHILD.

Please fill in the information on the reverse side of this form.

SECTION IV – ALLERGIES

Camper does not have any allergies

Camper is allergic to: *Food allergens:* _____

Drug allergens: _____

Environmental & other allergens: _____

Reactions: _____

Child requires an EpiPen

Dietary restrictions: _____

SECTION VI – MEDICAL HISTORY AND MEDICATIONS

Medical History:

Has your child experienced, or is currently experiencing, any of the following conditions? Explain “Yes” answers below.

Asthma/Inhaler	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest pain during exercise	<input type="checkbox"/> Yes <input type="checkbox"/> No
ADD/ADHD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Concussion	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bedwetting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dental Braces, Caps, or Bridges	<input type="checkbox"/> Yes <input type="checkbox"/> No
Behavioral Issues	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression/Mental Health/Eating Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Developmental Delays/Learning Needs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy/Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting/Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Homesickness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nightmares/Sleepwalking	<input type="checkbox"/> Yes <input type="checkbox"/> No
Severe Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Uses eyeglasses or contacts	<input type="checkbox"/> Yes <input type="checkbox"/> No
Urinary/Bowel Difficulties	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	<input type="checkbox"/> Yes <input type="checkbox"/> No
Operations	<input type="checkbox"/> Yes <input type="checkbox"/> No	Communicable Diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No
Injuries	<input type="checkbox"/> Yes <input type="checkbox"/> No	Activity Restrictions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Special Assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> 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.

Medications:

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.

Medication	Dose	Frequency	Notes (reason for medication etc.)	Time of day (i.e. breakfast, lunch, dinner)

Prescribing Physician: _____ Phone Number: _____

Does your child regularly take any medications that will not be taken at camp? Explain and identify if so: _____

I grant permission for the camp health personnel to administer over-the-counter medications indicated below:				
<input type="checkbox"/> Acetaminophen (Tylenol)	<input type="checkbox"/> Cold Medicine (Dimetapp, Robitussin)	<input type="checkbox"/> Antacids (Tums, Maalox)	<input type="checkbox"/> Sunburn Spray (Solarcaine)	<input type="checkbox"/> Antihistamines (Benadryl, Diphenhydramine)
<input type="checkbox"/> Anti-itch Cream	<input type="checkbox"/> Allergy Relief/Claritin	<input type="checkbox"/> Ibuprofen (Advil)	<input type="checkbox"/> Imodium	
<input type="checkbox"/> Sudafed	<input type="checkbox"/> Insect Repellent	<input type="checkbox"/> Sunscreen	<input type="checkbox"/> Antibiotic Cream	<input type="checkbox"/> Sting Swabs