

# West Central Youth Camp Medical Form

Fill out one copy for every camper including adults.

Campers Name: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Male  Female

Church camper came to camp with? \_\_\_\_\_

Pastor/Youth Pastor \_\_\_\_\_

Other adult sponsor \_\_\_\_\_

Will camper be taking medication while at camp? \_\_\_\_\_ If yes, please complete the following:

Medicine \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_

Medicine \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_

Has camper recently been under a doctor's care? If so, please explain on back of form. Please list any special health problems or handicaps on back of form. Please list any allergies the camper has on back of form. Please explain any behavior problem on back.

Check illnesses camper has had: Measles  Mumps  Chicken Pox  Polio

Whooping Cough  Kidney Ailments  Diphtheria  German Measles/Rubella

In case of emergency notify: Parent/Guardian \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Cell phone \_\_\_\_\_ other \_\_\_\_\_

Person to notify if parents cannot be reached: \_\_\_\_\_

Phone #1 \_\_\_\_\_ Phone #2 \_\_\_\_\_

**Consent for Medical Treatment:** I give full permission for my son or daughter to attend camp and to take part in all activities. My child will not attend if he or she has been exposed to a contagious disease, or if he or she is not in good physical condition. I do not hold the camp personnel or sponsor responsible for any accident or illness, and if necessary, authorize the camp personnel or sponsor to take my child to a doctor. I also give my full consent for the doctor selected to render professional services to my child, if he or she becomes ill or is involved in an accident.

Signature of Parent/Guardian \_\_\_\_\_

**Bogg Springs Campground** request that it's insurance be treated as supplemental insurance which will take effect after your personal insurance and most likely after any insurance your church may provide. In case of emergency, please provide the following Insurance Information:

Company Name \_\_\_\_\_ Phone # \_\_\_\_\_

Complete address \_\_\_\_\_

Group # \_\_\_\_\_ I.D. # \_\_\_\_\_

or Have the Doctor bill me at emergency contact information given above.