

MEDICAL / HEALTH FORM



men-o-lan
christian camp and retreat center
'that I may know Him' Phil 3.10

FOR: last name _____ first name _____

Men-O-Lan Christian Camp

Camp week(s) selected: _____

Name _____ Birthdate: ____ / ____ / ____

Parent/Guardian _____

Address _____ Phone: _____

Emergency Contact _____ Phone: _____

HEALTH HISTORY

Does the individual have special needs?: Yes No Explain: _____

Does the individual have allergies?: Yes No Explain: _____

Is this individual taking prescription or over the counter medication(s)? Yes No
If yes, indicate names of medications. All prescription medicines MUST have pharmacy labels, including name of prescribing doctor _____

List any other health information that we should be aware of or which may affect campers ability to participate in any activity. _____

Name of insurance _____ Name of insured _____
ID # _____ Group # _____

IMMUNIZATION HISTORY

Fill in month and year of the most recent booster vaccination.

Measles _____ Tetanus _____ Chicken Pox _____
Mumps _____ Hepatitis B _____ Rubella _____

This history is correct as far as I know. Camper has permission to engage in all camp activities. I authorize the camp nurse to administer the above medications to my child. I authorize the camp nurse to give over the counter medications such as tylenol, antacids, cough syrup, etc. as needed.

In the event I cannot be reached in an emergency, I hereby give permission for the physician selected by the Executive Director of Men-O-Lan Christian Camp and Retreat Center, or his/her designate, to transport, to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child named above.

Parent/Guardian signature _____ Date _____

Return this form one month prior to the camp week that will be attended.