PLEASE PRINT ALL INFORMATION PLEASE USE A SEPARATE FORM FOR EACH CHILD

Child Information

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____/_____/_____ Mark one: _____ Male _____ Female
Church: _____

Parent Information

Name: _____
Relation: _____
Home Phone: _____-_____-_____
Business Phone: _____-_____-_____
Cell Phone: _____-_____-_____
Email: _____

Medical Information

Medical Insurance Company _____
Medical Insurance Group Number _____
Medical Policy Number_____
Physician's Name: _____
Phone: _____-_____-_____
Please list any allergies (bee stings, food, medication, etc.): _____
_____
Are there any medications or precautions necessary for this allergy: _____
If yes, please list: _____
Is your child required to take medications or use an inhaler during conference hours: _____
If yes, please list: _____
Are there any limitations for camp activities (physical, verbal, auditory, etc.): _____
If yes, please list: _____

Consent for Emergency Medical Treatment and Medication

I hereby five consent to a registered nurse to administer without further consent over the counter medication as indicated by a physician or other medication prescribed by a physician. In case of emergency, I give authority to the Camp staff to obtain emergency treatment for my child. In addition, I authorize the doctor or hospital to perform any emergency procedure or operation, to give treatment and to administer anesthetics to my child during his/her stay at the Conference.

Print Name: _____ Date: _____/_____/_____
Signature:

Attach scanned copy of Medical Insurance Card