

CORTLAND BIBLE CLUB CAMP HEALTH FORM

Name _____ Birthdate _____ Sex _____ Age _____

Last
First
Initial

Parent or Guardian (or Spouse) _____ Phone _____

Home Address _____

Street and Number
City
State
Zip

Emergency Contact _____ Phone _____

ALLERGIES

(Please list all known allergies, and describe reaction and management of the reaction)

Medication, Food, or other Allergy	What is the reaction and how is it managed?

MEDICATIONS **

(Please list all known medications, dosages and times that the applicant takes)

Medication	Dosage / Time	Dosage / Time	Dosage / Time	Dosage / Time

**** ALL MEDICATIONS MUST BE BROUGHT TO CAMP IN THE ORIGINAL CONTAINER**

Any additional treatment to be continued at camp _____

Any current or chronic / recurring illness _____

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. **Authorization for Treatment:** I hereby give permission for the camp to provide ongoing and routine healthcare, to administer prescribed medications and seek emergency medical treatment including to order X-rays, routine test, treatment, and necessary transportation for me/or my child. I give permission to the camp to release any records necessary for insurance purposes. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child as named above **Permission to photo:** I hereby give permission to the officials at camp to take still, video, and digital pictures of me/or my child for the use of the camp in promotional publications, print, video, and on the World Wide Web.

Signature of parent or guardian or adult camper/staffer _____

Witness _____ Date _____