MEDICAL FORM

Peniel Bible Camp
3260 State Route 314
Fredericktown, Ohio 43019

PLEASE PRINT IN INK

Name _____

Birth Date _____/_____/_____ Age _____ ❑ Male ❑ Female

Parent / Custodial Guardian of minor _____

Home Address _____

City _____ State _____ Zip _____

Preferred Phone (_____) _____ ❑ Home ❑ Cell ❑ Work

Optional Phone (_____) _____ ❑ Home ❑ Cell ❑ Work

Additional Contacts (*Please make sure these people know that you have given their names as contacts*)

Name _____ Phone (_____) _____
❑ Home ❑ Cell ❑ Work

Name _____ Phone (_____) _____
❑ Home ❑ Cell ❑ Work

Family Doctor _____ Phone (_____) _____

(*Although a medical examination is not required, we remind you of the advisability of having a physical examination if there is any reason to suspect that the camper is having medical problems.)*

The above named person is capable of participating in all camp activities. ❑ Yes

❑ With exceptions: _____

_____

Date of last Tetanus shot _____

This form should be filled out and signed by a

- parent or legal guardian of a camper under the age of 18
- camper if 18 years of age or older
- camp staff member

This completed form must be

- mailed to "nurse" at the address above at least one week before the week of camp begins **OR**
- brought to camp with the camper/staff member

No medications are allowed in the cabins and must be turned in to the camp nurse upon arrival at camp.

Insurance: Insurance information is requested for emergency use only. (Optional: A copy of your insurance card may be attached to this form.)

Insurance Company_____

Policy # _____ Group # _____

Authorizations

- **Participation**: *This health history is correct so far as I know. Except as I have noted differently on this form, the above named person has my permission to engage in all camp activities.*
- **Medical Treatment**: *The camp nurse has my permission to administer, at her discretion, over-the-counter medications needed during the week.*
- **Emergency:** *In case of medical emergency, when a legal guardian cannot be reached, I give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection, anesthesia, dentistry or surgery for the above named person. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I authorize Peniel Bible Camp to secure copies of health records when/if seen by an out-of-camp provider.*
- **Photos**: *I give permission to Peniel Bible Camp to take and use photos that include this person in camp publicity.*

Date _____ Signature _____

❑ Parent ❑ Legal Guardian ❑ Camper over 18 years of age ❑ Staff member

Name: _____

Health History

☑ Please check areas in which there is a problem and explain below or on separate paper

❑ Diabetes ❑ Ear Infections ❑ Seizures ❑ Asthma ❑ Migraines

❑ Behavior/psychiatric ❑ Fears/Phobias ❑ Heart murmur or associated heart problem

❑ Contact lenses worn since _____ (year)

both eyes? _____ Type: ❑ Soft ❑ Hard

Allergies:

❑ Hay fever ❑ Asthma ❑ Poison ivy

❑ Food allergies (explain) _____

Type of allergic reaction / Treatment Given_____

Special diet items provided: _____

❑ Insect / Bee stings (explain) _____

Type of allergic reaction / Treatment Given_____

❑ Medicine allergies (explain) _____

Type of allergic reaction / Treatment Given_____

Immunizations:

_____ Hepatitis B _____ Diphtheria/Tetanus/Pertussis _____ Polio

_____ MMR _____ Hib (haemophilus influenzae) _____ Chicken Pox

_____ Hepatitis A _____ Prevnar (strep pneumonia) _____ Meningococcal

Preexisting medical conditions:

History of surgeries: _____,

_____

_____

Existing injuries or skin abrasions: _____

_____

Has camper/staff member been exposed to any communicable disease during the three weeks prior to camp attendance? _____ If so, explain: _____

_____

Has camper/staff member traveled outside the United States in the past year? _____

Where? _____ When? _____

Other concerns or details of above: _____

_____

_____

Medications

List all medications (prescription, over-the-counter, herbal, etc.) that are being brought to camp. Indicate if they are taken on a regular basis or as needed. Include any other pertinent information. Please note if medication has been added or changed in the past 3 months.

All medications will be turned in to the nurse during registration. **Please send all medications in the original package and label each with the camper's name**.

Common over-the-counter drugs are available from the camp nurse on an as-needed basis.

Name of Medication (Rx, OTC, herbal)	**Description** (i.e. color, liquid, capsule, etc.)	**Dosage** (times daily, as needed)	**Reason for taking medication**
			❑ New Medication ❑ Dosage changed
			❑ New Medication ❑ Dosage changed
			❑ New Medication ❑ Dosage changed
			❑ New Medication ❑ Dosage changed
			❑ New Medication ❑ Dosage changed

* * * * * * * * * * * * * * FOR OFFICIAL USE ONLY * * * * * * * * * * * * * *

Peniel Bible Camp review by_____

1. Signs/symptoms of illness/injury upon arrival? ❑No ❑Yes as noted below
2. History of exposure to communicable disease? ❑No ❑Yes as noted below
3. Additions/corrections to Health History information? ❑No ❑Yes as noted below
4. Medications turned in to Camp Nurse? ❑No ❑Yes as noted below

Notes: