

Camp Gideon: Medical Information and Authorization Form

Please print information in a legible manner

PARTICIPANT

INFORMATION

Name _____ Birth Date (MM/DD/YYYY) _____ Sex _____
Address _____ Phone _____
City _____ State _____ Zip _____ Email _____

FAMILY OR GUARDIAN INFORMATION

(Must be who the participant lives with and/or directs the participant's health care.
For Information that is the same as above, write "SAME" in the blank.)

Mother's or Guardian's Name _____ Cell Phone _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Email _____
Father's or Guardian's Name _____ Cell Phone _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Email _____

In case of emergency or we are unable to reach parent or guardian, please contact:

Name _____ Relationship _____ Phone _____ Work _____

MEDICAL INSURANCE INFORMATION

Name of policyholder _____ Policy/Group Number _____ Date _____
Name of insurance company/plan _____

MEDICAL HISTORY INFORMATION (check if yes)

Are you subject to: ___ sleepwalking ___ nervousness ___ easily upset ___ allergies (insects, foods, medication, etc.)

Please specify allergies and list reactions to watch for:

Allergy _____ Reaction _____

Please bring a copy of up to date immunizations.

Any significant disease, injury or operation (and corresponding dates)? _____

Any activity or dietary restrictions for medical reasons? _____

Any medical restrictions for cultural or religious restraints? _____

Medications currently taking. (List all medications, not just those being left at camp.)

Family Doctor _____ Phone _____
Dentist _____ Phone _____

Check preferred hospital: ___ Mercy Medical ___ Aultman ___ Salem ___ Alliance ___ Trinity East/West ___ Weirton ___ N/A

MEDICATION TO BE ADMINISTERED

Please list all medication given. MEDICATIONS, BY LAW, MUST BE DISPENSED FROM THE ORIGINAL BOTTLE.

Medication Name	Mark when medication is administered				
	Breakfast	Lunch	Dinner	Bedtime	Other Time
1.					
2.					
3.					
4.					
5.					
6.					
7.					

Please leave next grid blank. This grid is for medicine administering records.

For week of: _____

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Breakfast							
Lunch							
Dinner							
Bedtime							
Other Time							

MEDICAL AND INFORMATION RELEASE

Yes ___ No ___ I give my permission for necessary health care; for a licensed physician or dentist to provide medical treatment.

Yes ___ No ___ I give my permission for the release of information needed for necessary care of Participant.

Yes ___ No ___ I give my permission for staff at Camp Gideon to administer basic, over the counter medication to the Participant, such as Tylenol, Benadryl, etc., as well as distribute camper specific medication provided by the Participant (or parent/guardian).

AGREEMENT

I have read the entirety of this form, understand the content therein, agree to the appropriate releases, and attest that the information provided is accurate to the best of my knowledge.

PARENT/GUARDIAN SIGNATURES:

I hereby warrant that I am the legal parent or guardian of the child/camper/Participant and that I have the legal authority to sign these agreements on behalf of the child/camper/Participant.

Signature: _____ Date: _____

Signature: _____ Date: _____

(ALL parent/guardians if participant is a minor (under 18 years of age))

PARTICIPANT SIGNATURE: (Required if child/camper/Participant is over 18 years of age.)

Signature: _____ Date: _____