For Office Use Only		Date:	
Q #1		Q #3	
Q #2		Q #4	
Ob. Of Ind.		HCBC Staff Init.	

CONFIDENTIAL MEDICAL INFORMATION FORM

Effective 2/4/15

The following information is not part of the camper/staff acceptance process, but is gathered to assist in identifying appropriate care.

Full Name of Camper/Staff Member: _____ Date of Birth: _____

Address: _____

Gender: ❑ Male ❑ Female

List any conditions requiring restrictions from activities or other considerations while at camp. Please give full details and initial below (use back for more details):

_____

_____

Please list all current medications being taken and reason for taking them: _____

_____

(NOTE: All medications for campers must be turned over to Camp medical personnel during on-site camp check-in and **ALL MEDICATIONS MUST BE IN THE ORIGINAL CONTAINER FROM PHARMACY.**)

Record of Past Medical Treatment: (Indicate approximate date)

Frequent Problems or Disease

- ❑ Frequent Ear Infections
- ❑ Frequent Headaches
- ❑ Frequent Sore Throat
- ❑ Heart Defect/Disease
- ❑ Bedwetting
- ❑ Sleepwalking
- ❑ Bleeding/Clotting
- ❑ Seizures
- ❑ Diabetes
- ❑ Asthma
- ❑ Other _____
  _____
  _____

Allergies

- ❑ Hay Fever
- ❑ Ivy Poisoning
- ❑ Insect Stings
- ❑ Chlorine
- ❑ Drugs_____
- ❑ Food_____
- ❑ Other: _____

Immunizations

Immunizations up to date for school?

❑ Yes ❑ No

Date of last Tetanus shot:

_____

Operations or serious injuries (dates): _____

Dietary restrictions: _____

Name of Family Physician or Health Care Facility: _____ Phone: _____

Date of most recent physical exam: _____ (American Camping Association requires exam date within 24 months of attendance.)

Emergency Contact: _____ Phone: _____

Alternate Contact: _____ Phone: _____

Insurance: Do you carry medical/hospital insurance? ❑ Yes ❑ No

If so, indicate Carrier: _____ Policy Number: _____

The camper, volunteer and/or parent/guardian are responsible for all bills for medical treatments incurred while participating in the Camp program at Hickory Cove Bible Camp.

IMPORTANT: THIS BOX MUST BE READ AND COMPLETED FOR ATTENDANCE

AUTHORIZATION FOR TREATMENT:

By my signature below, I hereby give permission to the medical personnel selected by the Camp Administration to order X-rays, routine tests, and treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for the above-named camper. In the event I cannot be reached in an emergency or am otherwise unable to communicate with Camp authorities, I hereby give permission to the physician selected by the Camp Administration to secure and administer treatment, including hospitalization, for the above-named camper. This completed form may be photocopied. I hereby give permission for the information listed above, as well as any information concerning injury, illness, medical history, consultation, prescription, treatment or policy coverage for and about this camper, to be shared with necessary Camp personnel, outside medical personnel, pharmacists, and appropriate insurance company representatives, at the sole discretion of Hickory Cove Bible Camp, its staff and volunteers. I affirm that the above information is correct to the best of my knowledge, and I understand that it is my responsibility to update any and all information on this form if it changes between now and the start of the camp session.

Signature of Adult Camper/Staff (18 and older): _____ Date: _____

Signature of Parent/Guardian of Minor Camper/Staff: _____ Date: _____