

PARCHMENT VALLEY CONFERENCE CENTER

PERMISSION FOR EMERGENCY TREATMENT & HEALTH HISTORY

Please fill this form out as completely as possible for us to be able to provide the best care to you and your child while they are at camp. Every camper and adult needs a completed health form to participate in any of the Parchment Valley Conference Center camps.

SECTION I - BASIC CONTACT INFORMATION

Name: Last First Middle Birthdate: Age at Camp:

Home Address: Street Address City State ZIP Code

Gender: M F

Custodial Parent/Guardian:

Home Address: (If different from above) Street Address City State ZIP Code

Home Phone: Cell Phone: Work Phone:

If not available in an emergency, notify:

Relationship: Phone:

Address: Street Address City State ZIP Code

Family Physician Name: Phone:

Dentist/Orthodontist Name Phone:

SECTION II - AUTHORIZING SIGNATURE AND NOTARY

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests, treatment, to release any records necessary for insurance purposes, and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp. I understand that all reasonable attempts will be made to contact me as soon as possible after the condition necessitating treatment arises, and that failing to reach me, all reasonable attempts to contact the alternate listed above will be made. I understand that all reasonable precautions will be taken for safety at all times. I further release the West Virginia Baptist Convention, the Camp Cowen Board, the Parchment Valley Board of Directors, the West Virginia American Baptist Youth, and all persons associated with these organizations from any liability associated with any accident, injury or disease to the person who is the subject of this form.

SIGNATURE OF PARENT/GUARDIAN OR ADULT CAMPER/STAFFER:

STATE OF County of,

I, a qualified Notary Public, in and for the County aforesaid, hereby certify that the person whose signature appears above, did on this date, appear before me, after being duly sworn or affirmed, and reading this document in its entirety did affix his or her signature hereto in my presence.

NOTARY PUBLIC Date Executed

My Commission Expires: Please imprint seal in the area to the right:

SECTION III - INSURANCE INFORMATION - Please include a copy of your insurance card.

Please fill out the information below in the event of needing prompt health care for your child.

Is the participant covered by family medical/hospital insurance: YES NO

If so, indicate carrier or plan name: Group #

Carrier Address:

Address for Claims:

Policy Holder's Name: Relationship to Participant:

Policy Holder's Insurance ID Number: Employer:

Policy Holder's Social Security Number: Policy Holder's Date of Birth: / /

THANK YOU FOR HELPING US PROTECT YOU AND YOUR CHILD.

Please fill in the information on the reverse side of this form.

## SECTION IV – ALLERGIES

- Camper does not have any allergies
- Camper is allergic to: *Food allergens:* \_\_\_\_\_  
*Drug allergens:* \_\_\_\_\_  
*Environmental & other allergens:* \_\_\_\_\_  
 Reactions: \_\_\_\_\_
- Child requires an EpiPen
- Dietary restrictions: \_\_\_\_\_

## SECTION VI – MEDICAL HISTORY AND MEDICATIONS

### Medical History:

Has your child experienced, or is currently experiencing, any of the following conditions? Explain "Yes" answers below.

Asthma/Inhaler	Yes No	Chest pain during exercise	Yes No
ADD/ADHD	Yes No	Concussion	Yes No
Bedwetting	Yes No	Dental Braces, Caps, or Bridges	Yes No
Behavioral Issues	Yes No	Depression/Mental Health/Eating Disorder	Yes No
Developmental Delays/Learning Needs	Yes No	Diabetes	Yes No
Epilepsy/Seizures	Yes No	Fainting/Dizziness	Yes No
Homesickness	Yes No	Nightmares/Sleepwalking	Yes No
Severe Headaches	Yes No	Uses eyeglasses or contacts	Yes No
Urinary/Bowel Difficulties	Yes No	Other	Yes No
Operations	Yes No	Communicable Diseases	Yes No
Injuries	Yes No	Activity Restrictions	Yes No
Special Assistance	Yes No	Date of Last Tetanus Shot: _____	

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

**\*\* Child under 18:** Should your camper need immediate medical attention outside of camp, hospital emergency staff as well as paramedics need to know your child's Height: \_\_\_\_\_ ft \_\_\_\_\_ in Weight: \_\_\_\_\_ to provide proper treatment in your absence.

### Medications:

Will the camper be taking medications while at camp? YES NO

**ALL MEDICATIONS MUST BE TURNED IN to the medical personnel at registration. (INCLUDING prescription, over the counter, inhalers)** Please list all (prescription and non-prescription). Include the medication name, dosage, and dosage instructions. Use an additional sheet if needed. **Bring to camp all medications in their original packaging** that identifies the prescribing physician, the name of the medication, the dosage and the frequency of administration.

Medication	Dose	Frequency	Notes (reason for medication etc.)	Time of day (i.e. breakfast, lunch, dinner)

Prescribing Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Does your child regularly take any medications that will not be taken at camp? Explain and identify if so: \_\_\_\_\_

I grant permission for the camp health personnel to administer over-the-counter medications indicated below:

<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> Cold Medicine (Dimetapp, Robitussin)	<input type="checkbox"/> Antacids (Tums, Maalox)	<input type="checkbox"/> Sunburn Spray (Solarcaine)	<input type="checkbox"/> Antihistamines (Benadryl, Diphenhydramine)
<input type="checkbox"/> Anti-itch Cream	<input type="checkbox"/> Allergy Relief (Claritan)	<input type="checkbox"/> Ibuprofen (Advil)	<input type="checkbox"/> Imodium	
<input type="checkbox"/> Sudafed	<input type="checkbox"/> Insect Repellent	<input type="checkbox"/> Sunscreen	<input type="checkbox"/> Antibiotic Cream	<input type="checkbox"/> Sting Swabs