MEDICAL FORM

Sponsored by Grass Roots Ministries, Inc.

Last Name _____ First Name_____

Address _____ Phone _____

Age _____ Birth date _____/_____/_____ Sex_____ Height_____ft._____in. Weight_____

Parent/Guardian's Name _____ Daytime Phone_____

Parent/Guardian's Name _____ Daytime Phone_____

Other Emergency Contact _____ Daytime Phone _____

Family Doctor's Name _____ Doctor's Phone_____

My insurance is with _____ Policy Number _____

Allergies:

□ Medications_____ □ Insects stings or bites □ Animals_____

□ Seasonal (e.g. Hay fever) □ Foods_____ □ Other_____

Please describe reactions and treatments for any allergies. _____

_____

Please check if camper carries □ Epipen □ Medical Alert Bracelet □ Inhaler

General Health:

Please check if any of the following conditions apply to the camper.

□ Ear Aches □ Seizures □ Attention Deficit (ADD) □ Skin Conditions

□ Eating Disorders □ Homesickness □ Sinus Infections □ Heart Conditions

□ Sleepwalking □ Sore Throat □ Bronchitis □ Bedwetting

□ Head Aches □ Diabetes □ Emotional Concerns □ Stomach Aches

□ Asthma (Please indicate whether or not you carry an inhaler at all times) □ Yes □ No

Please explain extent of health issues _____

checked above, and treatments given. _____

Are all required immunizations current? □ Yes □ No

Please list any food allergies. _____

Please list any recent illnesses, injuries, or operations. _____

Please list any activity that should be limited while at camp and why. _____

Medications:

Please list any medications that you are currently taking and bringing to camp, using the table below. **Medication MUST be in original bottle or blister pack.** Name, name of medication, and dosage information must be clearly visible. You are not permitted to keep any medications in your cabin.

Prescription Medication	Dosage	Time of Day		As Needed Medication	Dosage	Reason for Giving

Does the camp's medical personnel have your permission to administer over-the-counter medications to your child, as required? (Such as Tylenol, antihistamine, antacid, etc.) □ Yes □ No

I give my permission to take a full and active part in the program at Camp Buckeye and to receive medical treatment in the case of an accident which may occur while I am registered at Buckeye. I understand that sickness is not covered by insurance. If medical treatment is necessary, I wish to be taken to a doctor. I further give permission & request that the named Rx medication(s) be given as ordered on the pharmacy container.

Signature: _____ **Name (please print)** _____ **Date:**_____

Signature:_____ **Name (please print)** _____ **Date:**_____

of parent or guardian if under 18