



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

## CONFIDENTIAL MEDICAL INFORMATION FORM

Effective 11/8/13

*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: \_\_\_\_\_