

STAFF MEDICAL INFORMATION & RELEASE

Name: _____ Sex: M F
Last First

dob: ___/___/___ Age: ___ Parent /Guardian's Name(if minor): _____

Mailing _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work _____

Phone: _____

Other Emergency Contacts:

Name _____ Phone # _____

Relationship: _____ Work # _____

Name: _____ Phone # _____

Relationship: _____ Work # _____

Date of most recent Tetanus booster: _____ Are all other immunizations up to date ? _____

Please send a copy of the immunization record with this form.

****Allergies** :**

Food allergies _____ Reaction: _____

Environmental allergies: _____ Reaction: _____

Drug allergies: _____ Reaction: _____

If more space is needed, please print on the back.

Medications presently taking: (prescriptions, over-the-counter, vitamins, creams, ointments. *All medication brought to camp by staff **must** be kept on your person, in your locked car or in the medical room with the camp nurse. Medications left in medical room will be secure locked and should be in original bottle with your name and the medication name written on it.*

Drug name(s)	Dosage & Directions	Reason Taking
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1. _____

2. _____

3. _____

4. _____

If more space is needed, please print on the back.

Hospitalizations? If yes, please explain: _____

Do you have asthma? ___ diabetes? ___ seizures? ___ high blood pressure? ___ Other? _____

Any medical, emotional, or physical disorder which could affect your ability to participate safely in all activities?

If yes, please explain: _____

Name/phone number of family physician: _____

Parental Authorization: (for minors only)

This information is correct so far as I know and the child herein described has permission to engage in all camp activities, except as noted by me and/or an examining physician. I give my permission for routine medical treatment to be administered by the camp medical personnel to the above named staff. **In the event I cannot be reached,** I give permission for camp personnel to obtain emergency transportation & emergency medical treatment for the health of my child. I will not hold Crossroads Christian Camp liable for the consequences of the reasonable exercise of authority by camp medical personnel so long as treatment is given in good faith with the best interest of my child in mind.

Parent/Guardian Signature: _____ Date: _____