2010

EMERGENCY MEDICAL RELEASE FORM

Martin Luther Christian School Summer Camp

NAME: _____ _____ _____
Last First Middle Initial

ADDRESS: _____ _____ _____ _____
Street City State Zip code

MALE:____ FEMALE:___ GRADE (FALL)_____ AGE:____ DATE OF BIRTH:___ / ___ / ___ PHONE:(___) _____

PARENT/GUARDIAN NAME: _____ PHONE: (___) _____

ADDRESS, CITY, STATE, ZIP: _____ _____ _____

FATHER'S EMPLOYER: _____ BUSINESS PHONE: (___) _____

MOTHER'S EMPLOYER: _____ BUSINESS PHONE: (___) _____

PARTICIPANT'S DOCTOR: _____BUSINESS PHONE: (___) _____

ADDRESS, CITY, STATE, ZIP: _____ _____ _____

CHURCH AFFILIATION: _____ PHONE: (___) _____

IF PARENT IS NOT AVAILABLE IN CASE OF EMERGENCY, NOTIFY:

NAME: _____ RELATIONSHIP:_____ PHONE: (___) _____

HEALTH HISTORY

The following information must be filled in by the parent/guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care.

LIST ANY ALLERGIES TO MEDICATION, FOOD AND OTHER (such as bee stings and asthma, hay fever, and such:)

1._____ 2. _____

3._____ 4. _____

WHAT SYMPTOMS INDICATE A REACTION? _____

IS PARTICIPANT CURRENTLY RECEIVING MEDICATION? NO: _____ YES: _____

IF YES, DESCRIBE MEDICATION FULL NAME, DOSAGE, ADMINISTRATION TIME(S) AND REASON BELOW:

1: _____

2: _____

3: _____

If your child must bring ANY MEDICATION to camp, it must be in the original container, clearly marked with camper's name. ALL medications will be kept in the infirmary with the health supervisor, who will see that it is properly administered.

LIST DIETARY RESTRICTIONS:

1._____ 2. _____

3._____ 4. _____

As parent or guardian; I hereby designate all matters of discipline and emergencies to camp authorities, and release Martin Luther Chapel, its principals, directors, officers and agents, employees and volunteers from any liability for accidents. I understand that if a serious injury develops, medical or hospital care will be given and I will be notified.

HOWEVER, IF IT IS IMPOSSIBLE TO CONTACT ME, I GIVE MY PERMISSION FOR EMERGENCY TREATMENT, X-RAYS, OR SURGERY, AS RECOMMENDED BY THE ATTENDING PHYSICAN AND/OR CHILD'S PHYSICIAN AND CAMP STAFF.

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____

HEALTH INSURANCE COMPANY: _____

POLICY NUMBER: _____