

Effective dates: January 1, 2017 to December 31, 2017

Please print in ink

Name: _____ Age _____ Birthdate _____
LAST FIRST MIDDLE

Grade in school _____ Male Female Email _____

Address _____ City _____ State _____ Zip _____

Phone _____ Student cell _____

Medical insurance company _____ Policy # _____
(PLEASE ATTACH A COPY OF INSURANCE CARD)

Mother's name _____ Phone: Home _____ Cell _____

Father's name _____ Phone: Home _____ Cell _____

Emergency contact _____ Phone: Home _____ Cell _____

Physician _____ Office phone _____

Dentist _____ Office phone _____

Medical History (Check all that apply. Provide additional details if needed)

Frequent Ear Infections Diabetes Hypoglycemic Bleeding Disorders Hay Fever Penicillin
 Heart Defect/Disease Asthma Mononucleosis Seizures ADD/ADHD Downs Syndrome
 Tourette's Syndrome Mumps Chicken Pox Measles Other (specify) _____ Ivy poisoning, etc.
 Insect Stings Drug or Food allergies (specify) _____

Chronic/recurring illness/medical conditions including mental illness (depression, anxiety, etc.)

Please explain: _____

Dietary Restrictions (medical and non-medical) _____

Blood Type (if known) _____ All immunizations current? Yes ___ No ___ Date Last Tetanus _____

What is your child's swimming ability? Non-Swimmer ___ Beginner ___ Intermediate ___ Advanced ___

Physical Restrictions (if any): _____

Allergies: No Known Allergies _____
 This Child is Allergic to: _____ Food _____ Medicine _____ Environment (Insect stings, hay fever, etc.) _____ Other _____

Please describe all known allergies, reactions seen and management to reaction: _____

Name: _____

DOB: _____

This form must be completed & signed by a parent or legal guardian. All prescription, over-the-counter, herbal, vitamin & nutrition supplement products will be kept by the Camp Nurse. These items must be given to the Camp Nurse upon arrival at camp (do not pack in child's luggage). All medications will be given as prescribed, indicated on this form or per label instructions by age and weight.

STOCKED OVER-THE-COUNTER MEDICATIONS: The following non-prescription medications (or equivalent) will be stocked in the camp infirmary and are used on an "as needed" basis to manage illness or injury only if approval as indicated below.

Medication	Indication	Individual Order <input type="checkbox"/> Yes to all	Special Instructions or Comments
acetaminophen (Tylenol)	pain, fever	Yes No	
ibuprofen (Advil, Motrin)	pain, fever, inflammation	Yes No	
phenylephrine HCl (Sudafed)	sinus congestion	Yes No	
guaifenesin (Robitussin)	chest congestion	Yes No	
dextromethorphan (Robitussin DM)	cough	Yes No	
diphenhydramine (Benadryl)	allergic reactions	Yes No	
phenol 1.4% spray (Chloraseptic)	sore throat	Yes No	
bismuth subsalicylate (Pepto Bismol)	GI symptoms	Yes No	
laxative (Milk of Magnesia, MiraLAX)	constipation	Yes No	
loperamide (Imodium AD)	diarrhea	Yes No	
calamine Lotion (Caladryl)	topical reactions	Yes No	
hydrocortisone 1% cream (CortAid)	topical allergic reaction	Yes No	
antibiotic ointment (Neosporin)	cuts, scrapes, abrasions	Yes No	
Aloe, burn gel	topical or sun burn	Yes No	

PRESCRIPTION & OTHER MEDICATIONS: Please list all current medications that you are sending to camp – both scheduled and as needed. "Medication" is any substance a person takes to maintain and/or improve health. This includes vitamins and natural remedies. Keep ALL medications in the original packaging. Prescription medication must have the full label issued from the pharmacy and will only be given to the person for whom it was prescribed.

Participant will NOT be bringing any medications to camp.

Participant WILL take the following medication(s) during camp.

Medication & Strength	Sig (specific directions including route)	Comments

ADDITIONAL ORDERS: Other health related needs – peak flow readings, dressing changes, blood sugar readings, etc.

IMPORTANT MEDICAL AUTHORIZATION:
I have reviewed this form in its entirety and give my permission (by selecting yes/no) for the acting medical staff to administer any medications (as defined above) as described above.

Signature of Parent/Guardian

Print Name

For your information, we expect each student to conform to these rules of conduct

- No possession or use of alcohol, drugs, or tobacco
- No fighting or "rough housing," weapons, fireworks, lighters, or explosives
- No offensive or immodest clothing
- No boys in girls' sleeping quarters and no girls in boys' sleeping quarters
- Participation with the group is expected
- Respect property
- Respect one another, staff, and adult leaders
- Respect and comply with event schedules
- Music (including CDs, iPods, or MP3 players), cell phones, and other devices may be confiscated and returned to the parent(s)/guardian(s) at the end of the trip if deemed inappropriate or a distraction from Christ.

Students who fail to comply with these expectations may be sent home at their parents' expense.

I, the student, have read the rules of conduct, the above evaluation of my health, and permission to participate in youth group activities. I agree to abide by the stated personal limitations and code of conduct.

Student signature: _____ Date: _____

Note: If you desire to limit your child's participation in any event, please submit your wishes in writing to the church youth pastor prior to that event.

This form is valid for Florida District of the Wesleyan Church Teen Camp 2017 "Thrive" and any other youth event put on by the Florida District sponsored by or in connection with The Florida District of the Wesleyan Church (hereinafter referred to simply as "the Church")

From: January 1, 2017 to December 31, 2017
DATE DATE

This consent form gives permission to seek whatever medical attention is deemed necessary, and releases the Church and its staff of any liability against personal losses of named child.

I/We the undersigned have legal custody of the student named above, a minor, and have given our consent for him/her to attend events being organized by the Church. I/We understand that there are inherent risks involved in any ministry or athletic event, and I/we hereby release the Church, its pastors, employees, agents, and volunteer workers from any and all liability for any injury, loss, or damage to person or property that may occur during the course of my/our child's involvement. In the event that he/she is injured and requires the attention of a doctor, I/we consent to any reasonable medical treatment as deemed necessary by a licensed physician. While every effort will be made to contact me as soon as possible, I understand and consent my permission for Florida District of the Wesleyan Church adult staff to make any necessary medical decisions regarding treatment for my child without necessity of first notifying me. In the event treatment is required from a physician and/or hospital personnel designated by the Church, I/we agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent. I/We also acknowledge that we will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance provider. Further, I/we affirm that the health insurance information provided above is accurate at this date and will, to the best of my/our knowledge, still be in force for the student named above. I/we also agree to bring my/our child home at my/our own expense should they become ill or if deemed necessary by the student ministries staff member.

Parent/guardian signature: _____ Date: _____

Signed and attested to before me this ____ day of _____, _____ by _____ who is personally known to me or has produced _____ as identification.

Printed name of Notary _____

Signature of Notary _____