SUSQUEHANNA CONFERENCE CAMP & RETREAT MINISTRY

2023 CAMP MEDICAL CONSENT FORM

Please complete both sides and sign this medical consent form. The registration process is complete when the registration and medical consent forms are submitted via mail, fax, or e-mail. 50% deposit due by May 1.

NOTE: Fee balance must be paid in full 2 weeks prior to the start of your week at camp.

CAMP DATE _____ **CAMP CODE** _____
(CAMP OFFICE ONLY)

CAMPER INFO:

Camper's Last Name _____ First Name _____ ☐ Male ☐ Female ☐ _____

Birthdate _____ Best E-mail (to receive pre-camp information) _____

Camper Address (Street, City, State, Zip) _____

Home Ph ( ) _____ Grade **COMPLETED** Spring 2023 _____

Name of Parent 1/ Guardian _____	Name of Parent 2/ Guardian _____
Address (if different from camper) _____	Address (if different from camper) _____
Home Ph ( ) _____	Home Ph ( ) _____
Work Ph ( ) _____	Work Ph ( ) _____
Cell Ph ( ) _____	Cell Ph ( ) _____

Emergency Contact Person other than Parent: _____ Relationship: _____

Emergency Contact Ph ( ) _____

INSURANCE/DOCTOR INFO:

Health Insurance Co. _____

ID/Policy No. _____ Group No. _____

Name of Primary Care Physician _____ Ph ( ) _____

Date of last physical _____ (current) Height _____ Weight _____

List any medications the camper is currently taking

Medication	Dosage	Instructions
1)		
2)		
3)		

List any food and/or drug allergies of the camper _____

What kind of reaction? _____

Are there any non-prescription medications you DO NOT want your child to receive? _____

Immunizations: Please fill out OR attach immunization report from physician or state health department

	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	___	___	___	___	___	___
TD (Tetanus/diphtheria)	___	___	___	___	___	___
Tetanus	___	___	___	___	___	___
Polio	___	___	___	___	___	
MMR	___	___				
Haemophilus influenza B	___	___	___	___		
Hepatitis B	___	___	___			
Varicella (Chicken Pox)	___	___				
COVID-19 Vaccine	___	___	___	___	(Manufacturer:_____)	

Does the camper need specific behavioral and/or emotional support? ☐ Yes ☐ No

If yes, please describe _____

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CIRCLE THOSE THAT APPLY AND EXPLAIN AS NECESSARY

ADHD	Bronchitis	Eye/Vision Problem	Learning Disability
Allergies	Concussion	Fainting	Nose Bleed
Anxiety	Convulsions/Epilepsy	Heart Defect/Disease	Poison Ivy
Asthma	Depression	Homesickness	Sleep Disorders/Sleepwalking
Bedwetting	Diabetes	Hypertension	Swimmer's Ear
Bleeding/Clotting Disorder	Ear Infections	Insect Stings	
Braces	Ear/Hearing Problem	Other Medical Conditions_____	

Explanation of above: _____

Disabilities: _____

Limitations or suggestions regarding activites: _____

Any other needs; best care practices, dietary restrictions, etc: _____

Is there any other information about the camper that we should know in seeking to best minister to their needs? (i.e. first time away from home, gender identity, recent traumatic event, etc.) _____

If your child/youth has been taken off medications for the summer by you, the parent/guardian, we highly recommend those medications be taken during their week of camp so your child/youth will have a quality experience.

MEDICAL CONSENT AND AUTHORIZATION: In the event of an emergency or non-emergency situation requiring medical treatment of the camper during their attendance at the camp, I/we, the undersigned parent(s)/guardian(s) of the camper, give the Camp Health Director my/our consent and authorization for all medical treatment that is deemed necessary by qualified medical personnel for the proper care and treatment of the camper, including but not limited to administration of first-aid, use of an ambulance, x-ray examination, administration of anesthesia, surgery and hospitalization.

Parent/Guardian Signature _____

Parent/Guardian Name (please print) _____

Relationship to the camper _____

Date _____

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Susquehanna Conference Camp & Retreat Ministry
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