Camp Attending ______________________

YEAR ______ CABIN OR GROUP ______ NAME ______

WEST VIRGINIA BAPTIST

Camps and Conferences

PERMISSION FOR EMERGENCY TREATMENT & HEALTH HISTORY

Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs. Please bring this form to camp on day of arrival. ANY PARTICIPANT WITHOUT A HEALTH FORM WILL NOT BE ALLOWED TO STAY AT CAMP.

Name ____ Birthdate ______________ Age at Camp ______________
Last First Middle

Home Address ____
Street Address City State Zipcode

Social Security Number of participant ______________________________ Gender: ☐M ☐F

Custodial Parent/Guardian ________________________________ Phone ______________

Home Address ____
(If different from above) Street Address City State Zipcode

Business Address ________________________________ Phone ______________
Street Address City State Zipcode

Second Parent/Guardian ________________________________ Phone ______________

Home Address ____
(If different from above) Street Address City State Zipcode

Business Address ________________________________ Phone ______________
Street Address City State Zipcode

If not available in an emergency, notify ____

Relationship ________________________________ Phone ______________

Address ____
Street Address City State Zipcode

Is the participant covered by family medical/hospital insurance: ☐YES ☐NO

If so, indicate carrier or plan name ______________________________ Group # ______________

Carrier Address ____

Name of Insured ______________________________ Relationship to participant ______________

Place of Employment ____

SOCIAL SECURITY # OF POLICY HOLDER OR INSURANCE ID # ______________________________

STATE OF WEST VIRGINIA

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp. I understand that all reasonable attempts will be made to contact me as soon as possible after the condition necessitating treatment arises, and, that failing to reach me, all reasonable attempts to contact the alternate listed above will be made. I understand that all reasonable precautions will be taken for safety at all times. I further release the West Virginia Baptist Convention, the Camp Cowen Board, the Parchment Valley Board of Directors, the West Virginia American Baptist Youth, and all persons associated with these organizations from any liability associated with any accident, injury or disease to the person who is the subject of this form.

SIGNATURE OF PARENT/GUARDIAN OR ADULT CAMPER/STAFFER ______________________________

County of, ______________________________, to wit:

I, a qualified Notary Public, in and for the County aforesaid, hereby certify that the person whose signature appears above, did on this date, appear before me, after begin duly sworn or affirmed, and reading this document in its entirety did affix his or her signature hereto in my presence.

______________________________ NOTARY PUBLIC

Date Executed ______________________________

My Commission Expires ______________________________

Please imprint seal in area to the right:

Please fill in information on reverse side of this form

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

- ❑ This person takes NO medications on a routine basis.
- ❑ This person takes medications as follows:

MED #1 ______________________ DOSAGE __________ TIME TAKEN EACH DAY ____________

REASON FOR TAKING ____

MED #2 ______________________ DOSAGE __________ TIME TAKEN EACH DAY ____________

REASON FOR TAKING ____

ATTACH ADDITIONAL PAGES FOR MORE MEDICATIONS.

IDENTIFY ANY MEDICATIONS TAKEN DURING THE SCHOOL YEAR THAT PARTICIPANT DOES/MAY NOT TAKE DURING THE SUMMER ____

ALLERGIES:

Allergy	Describe reaction and management of the reaction.
1. Medication Allergies (list)	
____________________________	____
____________________________	____
2. Food Allergies (list)	
____________________________	____
____________________________	____
3. Other Allergies (list) - include insect stings, hay fever, asthmas, animal dander, etc.	
____________________________	____
____________________________	____

WE ARE CONCERNED ABOUT THE SAFETY OF YOUR CHILD

In order to protect your child, please provide us with the following information:

Who will be picking your child up at the West Virginia Baptist Camp at Cowen at the close of camp?

NAME ____ Relationship to child ____________________

Is there anyone in particular whom you do not want to pick your child up at the close of camp? If yes, please list the name(s) below:

NAME ____

NAME ____

THANK YOU FOR HELPING US PROTECT YOUR CHILD.

NAME ____________________ CABIN OR GROUP ____________________ YEAR ____________