Emergency Contact Information

For Medical Supervisor

Father/Guardian

Last Name_____First Name_____

Address_____City_____State_____Zip_____

Daytime Phone_____Home Phone_____Cell Phone_____

E-Mail_____

Mother/Guardian

Last Name_____First Name_____

Address_____City_____State_____Zip_____

Daytime Phone_____Home Phone_____Cell Phone_____

E-Mail_____

Alternative Emergency Contact

Last Name_____First Name_____

Address_____City_____State_____Zip_____

Daytime Phone_____Home Phone_____Cell Phone_____

E-Mail_____

Relationship to Camper_____

***PLEASE INCLUDE A COPY OF THE CAMPER'S INSURANCE/MEDICAID CARD.**

Emergency Care Authorization

Camper's Name:_____

Child's Healthcare Provider

Name_____Phone Number_____

Emergency Medical Care Authorization:

I, the parent/guardian of _____ ,hereby give permission to Bound for Glory Camp to contact a doctor or emergency medical service and for the doctor, hospital or medical service to provide emergency medical or surgical care for my child should an emergency arise. It is understood that the Bound for Glory Camp staff will make a conscientious effort to locate the parent/guardian or emergency contact listed on the registration document before any action will be taken. If it is not possible to locate the emergency contact listed, I will accept the expense of emergency medical or surgical treatment.

Signature of parent/guardian_____Date_____

I, the parent/guardian of _____ ,give permission to the staff of Bound for Glory Camp to administer the following over the counter medications according to label instructions (**check all that you permit**):

__Advil/Tylenol type medicine __bug spray __sunscreen __antibiotic cream

__rash cream __sunburn lotion __antiseptic spray __Benadryl

Signature of parent/guardian_____Date_____

Health Information Card

Camper's Name_____ Sex: M or F D.O.B___/____/_____

Health History

List all allergies:

_____
_____
_____
_____

Yes/No

Asthma_____

ADD/ADHD_____

Cancer_____

Physical Disabilities_____

Sickle Cell____

Seizure Disorder____

Diabetes_____

Other physical or mental health issues which may be of concern while at camp:

_____
_____
_____

List any prescribed medications your child will be taking while at camp:

_____
_____
_____

List any non-prescription medications that your child will be taking while at camp:

_____
_____
_____

Date of last tetanus shot:

_____

Authorization to Give Prescribed Medication

Camper's Name:_____D.O.B___/___/___ Age_____

A. TO BE COMPLETED BY THE PHYSICIAN

Name of prescribed medication:_____

Reason for medication:_____

Form of medication: Tablet/Capsule/Liquid Other:_____

Restrictions and/or important side effects: Yes/No

If yes, please describe:

_____
_____
_____
_____
_____

Physician's Signature:_____Date:_____

Print Physician's Name:_____Phone:_____

Address:_____

B. TO BE COMPLETED BY PARENT/GUARDIAN

I, the parent/guardian of _____,give permission to the Health Care Director of Bound for Glory Camp to administer my child's prescribed medication as directed by his/her physician while at camp.

Parent/Guardian Signature:_____Date:_____

NOTE: ALL MEDICATIONS MUST BE DELIVERED TO CAMP BY A RESPONSIBLE ADULT IN THE CONTAINER IN WHICH IT WAS DISPENSED BY THE PRESCRIBING PHYSICIAN, LICENCED PHARMACIST, OR PHARMCY.