



# MEDICAL FORM

Peniel Bible Camp  
3260 State Route 314  
Fredericktown, Ohio 43019

PLEASE PRINT IN INK

Name \_\_\_\_\_

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_  Male  Female

Parent / Custodial Guardian of minor \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Preferred Phone (\_\_\_\_) \_\_\_\_\_  Home  Cell  Work

Optional Phone (\_\_\_\_) \_\_\_\_\_  Home  Cell  Work

**Additional Contacts** (Please make sure these people know that you have given their names as contacts)

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Home  Cell  Work

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Home  Cell  Work

Family Doctor \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

*(Although a medical examination is not required, we remind you of the advisability of having a physical examination if there is any reason to suspect that the camper is having medical problems.)*

The above named person is capable of participating in all camp activities.  Yes

With exceptions: \_\_\_\_\_

\_\_\_\_\_

Date of last Tetanus shot \_\_\_\_\_

This form should be filled out by a

- parent or legal guardian of a camper under age of 18
- camper 18 years of age or older
- camp staff member

This completed form must be

- mailed to "nurse" at the address above at least one week before the week of camp begins **OR**
- brought to camp with the camper/staff member

No medications are allowed in the cabins and must be turned in to the camp nurse upon arrival at camp.

**Insurance:** Please note that our insurance company requires that **your** insurance company be the **primary** insurer. Thus, any medical expenses will be billed to you. Expenses not covered by your insurance carrier may then be submitted to ours.

Insurance information is requested for emergency use only. (Optional: A copy of your insurance card may be attached to this form.)

Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

## Authorization

*This health history is correct so far as I know. Except as I have noted differently on this form, the above named person has my permission to engage in all camp activities, and the camp nurse has my permission to administer, at her discretion, over-the-counter medications needed during the week.*

*In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for the above named person. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.*

*I authorize Peniel Bible Camp to secure copies of health records when/if seen by an out-of-camp provider.*

Date \_\_\_\_\_ Signature \_\_\_\_\_

Relationship:  Parent  Legal Guardian  Camper over 18 years of age  Staff member

Name: \_\_\_\_\_

## Health History

Please check areas in which there is a problem and explain below or on separate paper

- Diabetes    Ear Infections    Seizures    Asthma    Migraines
- Behavior/psychiatric    Fears/Phobias    Heart murmur or associated heart problem
- Contact lenses worn since \_\_\_\_\_ (year)  
 both eyes? \_\_\_\_\_ Type:  Soft    Gas-permeable    Hard

### Allergies:

- Hay fever    Asthma    Poison ivy
- Food allergies (explain) \_\_\_\_\_  
 Type of allergic reaction / Treatment Given \_\_\_\_\_  
 Special diet items provided: \_\_\_\_\_
- Insect / Bee stings (explain) \_\_\_\_\_  
 Type of allergic reaction / Treatment Given \_\_\_\_\_
- Medicine allergies (explain) \_\_\_\_\_  
 Type of allergic reaction / Treatment Given \_\_\_\_\_

### Immunizations:

\_\_\_\_\_ Hepatitis B   \_\_\_\_\_ Diphtheria/Tetanus/Pertussis   \_\_\_\_\_ Polio

\_\_\_\_\_ MMR   \_\_\_\_\_ Hib (haemophilus influenzae)   \_\_\_\_\_ Chicken Pox

\_\_\_\_\_ Hepatitis A   \_\_\_\_\_ Pevnar (strep pneumonia)   \_\_\_\_\_ Meningococcal

### Preexisting medical conditions:

History of surgeries: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Existing injuries or skin abrasions: \_\_\_\_\_  
 \_\_\_\_\_

Has camper/staff member been exposed to any communicable disease during the three weeks prior to camp attendance? \_\_\_\_\_ If so, explain: \_\_\_\_\_  
 \_\_\_\_\_

Has camper/staff member traveled outside the United States in the past year? \_\_\_\_\_  
 Where? \_\_\_\_\_ When? \_\_\_\_\_

Other concerns or details of above: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Medications

List all medications (prescription, over-the-counter, herbal, etc.) that are being brought to camp. Indicate if they are taken on a regular basis or as needed. Include any other pertinent information. Please note if medication has been added or changed in the past 3 months.

All medications will be turned in to the nurse during registration. Please send all medications in the original package and label each with the camper's name.

Common over-the-counter drugs are available from the camp nurse on an as-needed basis.

Name of Medication (Rx, OTC, herbal)	Description (i.e. color, liquid, capsule, etc.)	Dosage (times daily, as needed)	Reason for taking medication
			<input type="checkbox"/> New Medication <input type="checkbox"/> Dosage changed
			<input type="checkbox"/> New Medication <input type="checkbox"/> Dosage changed
			<input type="checkbox"/> New Medication <input type="checkbox"/> Dosage changed
			<input type="checkbox"/> New Medication <input type="checkbox"/> Dosage changed
			<input type="checkbox"/> New Medication <input type="checkbox"/> Dosage changed

\*\*\*\*\* FOR OFFICIAL USE ONLY \*\*\*\*\*

Peniel Bible Camp review by \_\_\_\_\_

- Signs/symptoms of illness/injury upon arrival?    No    Yes as noted below
- History of exposure to communicable disease?    No    Yes as noted below
- Additions/corrections to Health History information?    No    Yes as noted below
- Medications turned in to Camp Nurse?    No    Yes as noted below

Notes: