

SUSQUEHANNA CONFERENCE CAMP & RETREAT MINISTRY
2020 CAMP MEDICAL CONSENT FORM

*Please complete both sides and sign this medical consent form.
The registration process is not complete until the registration and medical consent forms,
together with a 50% deposit, are submitted (via mail, fax, or e-mail).*

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

CAMP DATE _____ **CAMP CODE** _____

CAMPER INFO:

Camper's Last Name _____ First Name _____ M F Birthdate _____

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

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

Home Ph () _____ Grade **COMPLETED** Spring 2020 _____

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
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1) _____	_____	_____
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2) _____	_____	_____
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3) _____	_____	_____
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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? _____

Has camper had a tetanus shot in the past five years? Yes No If Yes, Date _____

Has camper ever had hepatitis? Yes No

Does camper have a history of behavioral or emotional problems? Yes No

If yes, please describe _____

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CAMPER NAME _____ CAMP CODE _____

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 activities: _____

Any other special needs, special care, or special diet: _____

Is there any other information about the camper that we should know in seeking to best minister to his/her needs at camp? (i.e. first time away from home, 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 his/her 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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