Indiana South District

rEVOLution—Teen Camp

Health and Medical Record / Release

GENERAL INFORMATION

Name _____ Date of Birth _____ Age ____

Address_____

City _____ State _____ Zip _____ Phone (____)_____

Church _____Youth Pastor/Leader_____

Health Insurance Company _____ Policy No. _____

ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD. IF YOU DO NOT HAVE MEDICAL INSURANCE, ENTER "NONE" ABOVE.

In case of an emergency, notify:

Name _____ Relationship_____

Home Phone (___)_____ Mobile Phone (____)_____

Name _____ Relationship_____

Home Phone (___)_____ Mobile Phone (____)_____

HEALTH HISTORY

Yes	No	CONDITION	EXPLANATION
		Asthma; Last Attack(MM/YY) _ _/_ _	
		Diabetes Type 1 ___ or Type 2 ___	
		Hypertension	
		Ear/Sinus problems	
		Psychological/Emotional problems/Behavioral problems	
		Seizures; Last Seizure (MM/YY) _ _/ _ _	
		Past Surgical Procedures (please include dates)	
		Other:	

Camper Name:

_____

Is your child allergic to or does your child have adverse reaction to any of the following?

YES	NO	ALLERGIES or REACTION to	EXPLANATION (Reaction, usual treatment)
		Medication	
		Food, Plants, Insect Bites	

MEDICATIONS

List ***ALL*** medications currently used. If additional space is needed, please photocopy this part of the health form. Inhalers and EpiPen information ***MUST*** be included, even if they are for occasional or emergency use only.

__ *No Medications* __ *See Attached Medication Sheets*

Medication _____ Strength _____ Frequency _____ Reason _____	Medication _____ Strength _____ Frequency _____ Reason _____	Medication _____ Strength _____ Frequency _____ Reason _____
Medication _____ Strength _____ Frequency _____ Reason _____	Medication _____ Strength _____ Frequency _____ Reason _____	Medication _____ Strength _____ Frequency _____ Reason _____

Please bring enough medication in sufficient quantities and in the ***ORIGINAL*** containers. Any medication not in original containers will ***NOT*** be administered. Please include inhalers and EpiPens.

I give my permission for the leaders of rEVOLution to coordinate medical care for my child. I understand that the camp leaders will exercise due care for the safety of campers, but I recognize that accidental injuries may occur. In the case of an emergency, I understand that the leaders will try to contact me immediately. If I cannot be reached, I authorize camp leadership to organise transport for my child to a hospital or urgent care in order to receive any medical care urgently required. This health record is correct so far as I know. My child has permission to engage in all program activities, except as noted. (Please attach any further details).

_____ _____

PARENT/GUARDIAN SIGNATURE DATE