

**Emergency Medical Health
Information Form**
North Georgia
Youth Music & Worship Arts Camp
2019

Camper Name

First Middle Last

Male Female __/__/__ _____
Date of Birth Age on arrival at camp

Camper Name

First

Middle

Last

Room Number

Emergency Contact Information

Parent/Guardian(s) Name: _____

Home Phone _____ Work _____ Cell: _____

What is the best way to reach you during camp? _____

Home Address _____ City _____ Zip _____

If person named above cannot be reached in case of emergency, notify:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

General Medical History

Any allergies? _____

Any special diet requirements or restrictions? _____

Past medical history/injuries we should be aware of: _____

Date of last Tetanus shot: _____

Name of physician: _____

Address & Phone #: _____

Insurance Information

Group Or Family Hospitalization Insurance Company: _____

Insurance Company's Address: _____

Policy #: _____

Name of Insured: _____

Copy of Medical Card attached: _____ yes

Medication

Camper does not currently take any medication

Camper takes the following medication (please include dietary supplements)

Medication	Purpose of Medication	Administration time	Dosage	Method of administration
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other: _____		
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other: _____		
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other: _____		
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		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other: _____		

First Aid Over The Counter Medications

The following over the counter medications may be part of the Camp Nurse First Aid Kit and are used on an as needed basis to manage illness and injury. Please cross out those the camper should not be given.

Acetaminophen (Tylenol)
Phenylephrine decongestant (Sudafed PE) Antihistamine/allergy medicine
Diphenhydramine antihistamine/allergy medicine (Benadryl) Sore throat spray
Lice shampoo or cream (Nix or Elimite)
Calamine lotion
Laxatives for constipation (Ex-Lax)
Ibuprofen (Advil, Motrin)
Pseudoephedrine decongestant (Sudafed)
Guaifenesin cough syrup (Robitussin)
Dextromethorphan cough syrup (Robitussin DM)
Generic cough drops
Antibiotic cream
Aloe
Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

Waiver of Responsibility

I, _____, legal parent or Guardian of _____, give my permission to him/her to participate in all activities at camp. I hereby release Reinhardt University, The Fellowship, its staff, and volunteer counselors of any liability in the event of accident or injury. Should emergency medical treatment be necessary, I authorize the Camp Staff to act on my behalf and approve appropriate treatment.

I hereby give permission to the nurses or physicians selected by the Camp Staff to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my child named above as deemed necessary to avoid extreme or permanent physical damage or death.

Signed: _____

Date: _____

Notarization

Notary Public Signature _____

Month: _____ Day: _____ Year: _____

Notary Seal must be stamped here