Camp Sharon Medical Information, Consent & Release

(Also complete a Camper Registration Form. Please print clearly in ink.)

Camper Name _____ ☐Male ☐ Female

Address _____ City / State / Zip _____

Phone (_____)_____– _____ Alt. Phone 1 (_____)_____– _____ Alt. Phone 2 (_____)_____–_____

Date of Birth (mm/dd/yyyy)_____/____/_____ Camper's Social Security Number_____-____- _____

Health Insurance Company Name / Medicaid _____

Policy # _____ Group # _____

Policy Holder's Name _____

Physician's Name _____ Physician's Phone (_____)_____– _____

Medications: List over-the-counter medications or prescriptions, dosage and frequency. All medications brought to camp must be in the original containers, clearly labeled with camper's name and dosage instructions.

_____

_____

Allergies: List any known allergies to food, drugs, plants or animals; the reaction and medication used to treat.

_____

Restrictions: Any activity or medication restriction desired by participant, the parent/guardian or physician?

_____

Date of last known tetanus shot _____ **Does the camper wear contacts?** ☐YES ☐ NO

Check if prone to any of the following:

☐Fainting	☐Stomach upset	☐Convulsions	☐Asthma
☐Diabetes	☐Bedwetting	☐Sleepwalking	☐Other respiratory problems
☐ADD / ADHD	☐Headaches	☐High blood pressure	☐Heart problems

☐Other conditions (please explain) _____

Medical Release and Consent for Medical Treatment and Medications

I, the undersigned, hereby give my consent for my child to participate in the Church of God enterprise for which he/she is enrolled, and in consideration for allowing my child to participate, I release and all rights or claims for damages against the Missouri Minis tries of the Church of God and Camp Sharon, and all individuals assisting, instructing and conducting these activities, for any and all injuries, loss, or damage suffered by my child while attending said enterprise. I give my consent to the camp nurse/health supervisor to administer medications that I provide for my child, following my directions or the directions of the prescribing physician. The camp nurse/health supervisor may also administer over-the-counter medication as needed for the well-being of my child; unless I otherwise restrict its use (listed above). I understand that, in the event medical treatment is required, every effort will be made to contact me. However, if I cannot be reached, I give my permission to the camp staff or counselor to secure the services of a licensed physician or emergency room of a hospital to provide the care necessary, including anesthesia, for my child's well-being. I also understand that I or my insurance company am responsible for the medical cost incurred.

Father's Signature _____ **Date** _____

Mother's Signature _____ **Date** _____

Guardian's Signature _____ **Date** _____

Please send Registration form along with Medical information and at least the pre-registration amount of $40.00/person to Missouri Ministries of the Church of God • PO Box 217 • St James, MO 65559 • PH: 573-265-8545 • FX 573-265-5113

Camp Sharon provides services to all persons without regard to race, color, national origin, age, sex or handicap – (Rev 2/2019)