WEST VIRGINIA BAPTIST CONFERNCE CENTER
Brothers' Keeper
PERMISSION FOR EMERGENCY TREATMENT & HEALTH HISTORY

Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs. Please send this form with your registration. ANY PARTICIPANT WITHOUT A HEALTH FORM WILL NOT BE ALLOWED TO STAY AT CAMP.

Name ____ **Birth date** ______________ **Age at Camp** _____________
Last First Middle

Home Address ____
Street Address City State Zip code

Social Security Number of participant ____ **Gender: M F**

Custodial Parent/Guardian ____ **Phone** _____________________

Home Address ____
(If different from above) Street Address City State Zip code

Business Address ____ **Phone** _____________________
Street Address City State Zip code

Second Parent/Guardian ____ **Phone** _____________________

Home Address ____
(If different from above) Street Address City State Zip code

Business Address ____ **Phone** _____________________
Street Address City State Zip code

If not available in an emergency, notify ____

Relationship ____ **Phone** _____________________

Address ____
Street Address City State Zip code

Is the participant covered by family medical/hospital insurance: YES NO **Please attach copy of medical card**

If so, indicate carrier or plan name ____ **Group #** ___________________

Carrier Address ____

Name of Insured _____________________________________ **Relationship to participant** __________________________

Place of Employment ____

SOCIAL SECURITY # OF POLICY HOLDER OR INSURANCE ID # ____

STATE OF WEST VIRGINIA **Please fill in information on reverse side of this form**

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp. I understand that all reasonable attempts will be made to contact me as soon as possible after the condition necessitating treatment arises, and, that failing to reach me, all reasonable attempts to contact the alternate listed above will be made. I understand that all reasonable precautions will be taken for safety at all times. I further release the West Virginia Baptist Convention, the Parchment Valley Board of Directors, the West Virginia American Baptist Youth, and all persons associated with these organizations from any liability associated with any accident, injury or disease to the person who is the subject of this form.
SIGNATURE OF PARENT/GUARDIAN OR ADULT CAMPER/STAFFER ____

County of, ____, **to wit:**

I, a qualified Notary Public, in and for the County aforesaid, hereby certify that the person whose signature appears above, did on this date, appear before me, after begin duly sworn or affirmed, and reading this document in its entirety did affix his or her signature hereto in my presence.

____ **NOTARY PUBLIC**

Date Executed ____

My Commission Expires ____
Please imprint seal in area to the right

Date of Last Tetanus Shot: ________________

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person takes NO medications on a routine basis.

This person takes medications as follows:

MED #1 _________________________ **DOSAGE** ___________ **TIME TAKEN EACH DAY** ______________

REASON FOR TAKING ____

MED #2 _________________________ **DOSAGE** ___________ **TIME TAKEN EACH DAY** ______________

REASON FOR TAKING ____

MED #3 _________________________ **DOSAGE** ___________ **TIME TAKEN EACH DAY** ______________

REASON FOR TAKING ____

ATTACH ADDITIONAL PAGES FOR MORE MEDICATIONS.

IDENTIFY ANY MEDICATIONS TAKEN DURING THE SCHOOL YEAR THAT PARTICIPANT DOES/MAY NOT TAKE DURING THE SUMMER ____

ALLERGIES:

Describe reaction and management of the reaction.

1. Medication Allergies (list)

____ ____

____ ____

____ ____

2. Food Allergies (list)

____ ____

____ ____

____ ____

3. Other Allergies (list) - include insect stings, hay fever, asthmas, animal dander, etc.

____ ____

____ ____

____ ____

SPECIAL DIETARY NEEDS:

Gluten Free Diet **YES** **NO** Other food allergies or special dietary needs: ________________________________

Lactose Intolerance **YES** **NO** ____

Parent/Guardian
Pease initial here____________ The information provided here in is accurate to the best of my knowledge.