

Camp Attending: _____ Year: _____

PARCHMENT VALLEY CONFERENCE CENTER PERMISSION FOR EMERGENCY TREATMENT & HEALTH HISTORY

Please fill this form out as completely as possible for us to be able to provide the best care to your child while they are at camp.
Every camper needs a completed health form to participate in any Parchment Valley summer camp programs.

SECTION I – BASIC CONTACT INFORMATION

Name _____ Birthdate _____ Age at Camp _____
Last First Middle

Home Address _____
Street Address City State ZIP Code

Social Security Number of participant _____ Gender: M F

Camper Lives With: Mother & Father Mother Father Grandparent Other: _____

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

If not available in an emergency, notify _____

Relationship _____ Phone _____

Address _____
Street Address City State ZIP Code

Family Physician Name _____ Phone _____

Dentist/Orthodontist Name _____ Phone _____

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 Camp Cowen Board, 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 _____

SECTION II – NOTARY

STATE OF WEST VIRGINIA

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 the area to the right:

SECTION III – TRANSPORTATION

In order to protect your child, please provide us with the following information:

Who will be picking up your child at the Parchment Valley Conference Center at the close of camp?

Name _____

Is there anyone in particular whom you do not want to pick up your child at the close of camp? If yes, please list the name(s) below:

Name _____

Name _____

THANK YOU FOR HELPING US PROTECT YOUR CHILD.

**Any changes
to this form
must be
reported at
registration.**

**SECTION IV – INSURANCE INFORMATION – Please include a copy of your insurance card.
Please fill out the below information in the event of needing prompt health care for your child.**

Is the participant covered by family medical/hospital insurance: YES NO
 If so, indicate carrier or plan name: _____ Group # _____
 Carrier Address: _____
 Address for Claims: _____
 Policy Holder's Name: _____ Relationship to Participant: _____
 Policy Holder's Insurance ID Number: _____ Employer: _____
 Policy Holder's Social Security Number: _____ Policy Holder's Date of Birth: ____/____/____

SECTION V – MEDICATIONS AND RESTRICTIONS

Will the camper be taking medications while at camp? YES NO

ALL MEDICATIONS MUST BE TURNED IN to the medical personnel at registration. (INCLUDING prescription, over the counter, inhalers) Please list all (prescription and non-prescription). Include the medication name, dosage, and dosage instructions. Use an additional sheet if needed. Bring to camp all medications in their original packaging that identifies the prescribing physician, the name of the medication, the dosage and the frequency of administration.

| NAME OF DRUG | DOSAGE AMT. | TIMES GIVEN | TOTAL DAILY DOSE | REASON FOR MEDICATION | SPECIAL INSTRUCTIONS |
|--------------|-------------|-------------|------------------|-----------------------|----------------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Prescribing Physician: _____ Phone Number: _____

Identify any medications the camper takes during the school year that the camper does not/may not take during the summer:

| | | | | | | | | | | | |
|--|-----|----|--------------|-----|----|----------------|-----|----|-------------------------|-----|----|
| I grant permission for the camp health personnel to administer over-the-counter medications indicated below: | | | | | | | | | | | |
| Tylenol | yes | no | Motrin/Advil | yes | no | Pepto-Bismol | yes | no | Maalox/Tums | yes | no |
| Imodium | yes | no | Benadryl | yes | no | Cough Medicine | yes | no | Allergy Relief/Claritin | yes | no |
| Parent signature for over the counter administration: _____ | | | | | | | | | | | |

Medical History or Special Instructions for Minor Illness:

Please provide information (past or present) on any **recent illness** (fevers, infections, rashes, cough, headaches) or **injuries** (i.e. broken bones, asthma, concussion, surgeries) or **special instructions** for minor illnesses. Unless specific instructions are provided, the camp health professional will treat minor illnesses with over-the-counter medications. If the illness persists, parents will be notified.

Has your child ever been put on concussion protocol? NO YES If so, when? _____

Has your child ever tested **POSITIVE** for COVID-19: NO YES If so, when? _____

**** Child under 18:** Should your camper need immediate medical attention outside of camp, hospital emergency staff as well as paramedics need to know your child's **Height:** ____ft ____in **Weight:** _____ to provide proper treatment in your absence.

SECTION VI – ALLERGIES

Camper does not have any allergies

Camper is allergic to: Poison Ivy/Oak Insect Stings Medications: _____ Food Allergy: _____

Reactions: _____