

Μεδικαλ Ηιστορψ

Name

Camper

******If child has been exposed to any communicable disease within two weeks prior to their stay, please do not send them to the retreat.**

List any operations, illnesses or injuries during the past twelve months: _____

Other injuries or limitations: _____

Date of last DPT or DT booster: _____

Any allergic reactions to the following:

___ Bee Sting ___ Penicillin ___ Hay Fever ___ Poison Ivy ___ Oak ___ Other: _____

Treatment required for allergy: _____

Does your child have any of the following problems:

___ Asthma ___ Bronchitis ___ Bed Wetting ___ Fainting ___ Diabetes ___ Frequent Colds

___ Sinusitis ___ Heart Trouble ___ Diarrhea ___ Sore Throat ___ Sleep Walking ___ Convulsions

___ Ear Infections ___ Other: _____

Please provide details: _____

Please check the medications the camp may administer:

___ Tylenol ___ Ibuprofen ___ Antihistamine ___ Aloe Vera ___ Mylanta ___ Cough Medicine

___ Cough Syrup ___ Cold Tablets ___ Other: _____

Legible written physician's directions should accompany any prescription medication to camp. Include type of medication, dosage, frequency, condition being treated, physician's signature and DEA Number. For the safety of all our campers, medication should be administered by church or retreat staff. It is the responsibility of parent or guardian to make these arrangements.

In the event that I am unavailable for purposes of providing parental consent, I hereby authorize the physician(s) and staff of Garden Park Medical Center or any Medical Facility deemed necessary by Church or retreat staff to provide such hospital care that includes diagnostic procedures and medical treatment as necessary to my minor son or daughter while enrolled in the Youth Retreat held at Palmer Creek Methodist Campground. Said medical treatment may be given without any further prior permission from the undersigned. I also authorize payment of medical benefits for any services furnished to my child by physicians or staff at the above facility. I authorize you to release to my insurance company information concerning the health care provided to my child while attending the Retreat. In the event of any injury or illness requiring transportation to an independent medical facility, I authorize the release of all medical records generated at the facility to the Church and retreat staff. I understand this will enable a continuity of care upon the camper's return and will provide staff a means of informing family members of the camper's medical condition. Such records will remain a confidential part of the camper's general record.

I understand that the consent and authorization does not include any elective surgical procedures but includes any life saving treatment deemed necessary by the above facilities. I will be contacted as soon as possible in the event my child is taken to the hospital for treatment.

Signature of Parent or Guardian _____ Date _____

Πλεασε ατταχη ανψ αδδιτιοναλ μεδικαλ χονχερνεσ.

Πλεασε προπιδε α πητοχοπψ οφ βοτη φροντ ανδ βαγκ οφ μεδιχαλ ινσυρανχε χαρδ.