Medical Release/Consent

Camper Last Name _____ First Name_____ Middle Initial _____

Date of Birth ___/___/___ Gender M / F Age_____

The undersigned acknowledges and understands that the above named camper's ("Camper") participation in the Camp Program and related recreational activities may involve risks to the Camper's physical well-being. With full knowledge of said risks and in consideration of the benefits derived by the Camper in the participation of the camp and programs, I hereby consent, approve, covenant and agree to indemnify and save harmless Bridgeport Camp & Conference Center and the North Texas Conference of the United Methodist Church, their agents, servants, employees, representatives, volunteers and staff from and against all actions or causes of action, claims, demands, liabilities, loss, or damage to the Camper resulting or arising out of the Camper's attendance at the Camp or participation in any Camp related activity of any kind, including, without limitation, any cause of action sounding in negligence.

In the event I cannot be reached in a medical emergency, I hereby give my consent and authorization for medical treatment by a health care professional for the purpose of preserving the life and/or well-being of the above named Camper. I hereby give permission to the camp nursing staff to administer any necessary first aid should a situation requiring medical attention occur while at camp and IN CASE OF EMERGENCY, give permission to the medical personnel selected by the Camp Director or authorized staff to order X-rays, routine tests, treatment, to release any and all records necessary for insurance purposes and to provide or arrange necessary related transportation for me/my camper. 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. I hereby give permission to the camp nursing staff to administer prescription medication (as noted) and over-the-counter medication (PRNs) as deemed necessary.

Signature: _____ Date: _____

Circle: Parent / Guardian / Managing Conservator of Minor Child

THE STATE OF TEXAS

COUNTY OF _____

BEFORE ME, the undersigned authority, on this day personally appeared _____,
Known to me to be the person whose name is subscribed to the above Medical Release/Consent and acknowledge to me that he/she executed the same for the purposes and consideration therein expressed.

GIVEN UNDER MY HAND AND SEAL OF OFFICE this ____ day of _____, _____.

_____
Notary Public, State of Texas

Attach a copy of Immunization Record and copy of your Insurance Card to Camp Form

SEEK Camp Medical Form

Camper Last Name _____ First Name _____ Middle Initial _____

Date of Birth ___/___/___ Gender M / F Age_____

Address _____City _____ State ____ Zip Code _____

Mother's Name _____ Father's Name _____

Home Phone _____ His Wk Phone _____ His Cell _____

Her Wk. Phone _____ Her Cell _____

Emergency Contact (other than parent)_____ Relationship _____

Home Phone _____ Wk Phone _____ Cell _____

Physician Name_____ Office Phone _____

Dentist Name _____ Office Phone _____

Orthodontist Name _____ Office Phone _____

Insurance Carrier/Plan Name _____ Group # _____

Policy # _____ Name of Policy Holder _____

Insurance Phone # _____

Adequate disclosure of health history is crucial in providing the best care to your child.
We want to provide a supportive, safe, and healthy camp environment to all campers and staff.

ALLERGIES – List all known:

Medical Allergies	_____	Reaction & Treatment	_____
	_____		_____
	_____		_____
Food Allergies	_____	Reaction & Treatment	_____
	_____		_____
	_____		_____
Other Allergies	_____	Reaction & Treatment	_____
	_____		_____
	_____		_____

GENERAL HISTORY – Mark the appropriate response for each statement:

Yes__ / No__ This Camper has had chicken pox or varicella vaccination.
Yes__ / No__ This Camper has had mononucleosis in the past 12 months.
Yes__ / No__ This Camper has a history of illness, injury, or surgery which will affect participation.
If yes, please explain: _____
_____

Chronic Concerns – Check all that apply to your camper and provide any helpful information for care.

☐ This Camper has NO chronic health concerns and is capable of full participation at camp.
☐ This Camper has the following health concern(s):
___ Asthma (even if inhaler is only used occasionally)
___ Frequent ear infections _____
___ Migraine headaches _____
___ Enuresis (bed-wetting) _____
___ Depression, ADD, ADHD, Oppositional Behavior Disorder _____
___ Anorexia, Bulimia (eating disorders) _____
___ Diabetes _____
___ Seizures, If so, please describe _____
___ Any other chronic illness? _____
_____

Supportive Care – Check all that apply to your camper and provide any helpful information for care.

This Camper has the following health concern(s):
___ Glasses ___ Hearing Aid(s) ___Wheelchair ___ Walker ___Communication Device ____ Dental Appliances
___ Braces If so, can braces be removed? _____ If so, for how long? _____
___ Catheterized If so, how often? _____ Can Camper do this? _____
___Other special equipment _____
_____

Diet – Please note that camp is not equipped to prepare special diets for campers. If your camper has special dietary needs, please notify the camp director will in advanced of your camper's arrival to camp. Some dietary restrictions can be accommodated; however, these must be addressed prior to camp.

Special Needs – Are there any special concerns that you have as a parent or guardian regarding the medical and health needs of your child while at SEEK Camp? If so, please explain below in detail:

MEDICATIONS:

- This Camper does not take any medications on a regular basis.
- This camper takes routine medications

Bring enough to last all week.

Please list all prescription medication, over-the-counter, and non-prescription drugs taken regularly.
Fill in all blanks completely.

Medication	Reason	Dose	When it is taken
1.			
2.			
3.			
4.			
5.			
7.			
8.			
9.			
10.			

SEEK Camp

Parent Authorization to Administer Medication

Camper Name:_____

SEEK camp personnel must have written parental consent in order to administer over-the counter medication (OTC). Generic equivalents maintained by the nurse may be used in place of brand name. OTC medications will be administered sparingly and according to standardized dosing instruction when indicated to make your child more comfortable.

Please check off the medication that you give permission for your child to receive and **CROSS OUT** any that should not be given:

Pain reliever / Fever reducer
- ☐ Acetaminophen (generic Tylenol)
- ☐ Ibuprofen (generic Motrin or Advil)

Constipation / Diarrhea
- ☐ Milk of Magnesia
- ☐ Immodium

Cold / Congestion / Allergy
- ☐ Diphenhydramine (generic Benadryl)
- ☐ Robitussin DM
- ☐ Cough Drops
- ☐ Chloroseptic Spray

Skin
- ☐ Calamine Lotion
- ☐ Hydrocortisone Cream
- ☐ Neosporin Ointment
- ☐ Sunburn lotion

Antiseptics
- ☐ Rubbing Alcohol
- ☐ Hydrogen Peroxide

Eye Wash
- ☐ Saline Eye Wash

Indigestion
- ☐ Tums
- ☐ Pepto Bismol

I hereby authorize the nurse to administer medication designated on this form in accordance to standardized dosing instructions. I understand that any nurse who administers these medications according to proper dosages shall not be held liable for damages as a result of an adverse reaction to the medications administered.

Parent/guardian_____ Date_____

- ☐ I **DO NOT** want any of the above medications given to my child at camp.

This page must be completed by a licensed Physician or Nurse Practitioner and can be based on an examination within the past year prior to the Camper's session at camp.

MEDICAL RECOMMENDATION:

Camper Last Name _____ First Name _____ Middle Initial _____

Date of Birth ___/___/___ Gender M / F Age_____

Height _____ Weight _____ Blood Pressure _____

This camper is under the care of a physician, or has been in the past, for the following: _____

_____

Treatment to be continued at SEEK Camp for this Camper: _____

_____

Routine medications that this Camper will be on while attending SEEK Camp are: _____

_____

Camper is allergic to the following: _____

Treatment for allergic response: _____

List any restriction that this Camper should have at SEEK Camp and describe the limitations:

_____

Additional health information needed for a successful experience at SEEK Camp: _____

_____

MD/NP Signature _____ Date _____

MD/NP Name _____

Office Phone _____

Address _____