

KCPC CAMPS
EMERGENCY MEDICAL FORM

**TO BE COMPLETED BY LEGAL
GUARDIAN – BRING TO CAMP!**

CAMPER'S INFORMATION: (please print)

NAME:			D.O.B. / /	AGE:
<i>LAST</i>	<i>FIRST</i>	<i>M.I.</i>	PHONE#	
ADDRESS			SSN	
CITY	STATE	ZIP		

PARENTS/LEGAL GUARDIAN CONTACT INFORMATION (FULL NAME)

FIRST CONTACT:	
RELATIONSHIP TO CAMPER:	DAY PHONE:
	EVENING PHONE:
	MOBILE PHONE:
SECOND CONTACT:	
RELATIONSHIP TO CAMPER:	DAY PHONE:
	EVENING PHONE:
	MOBILE PHONE:
THIRD CONTACT:	
RELATIONSHIP TO CAMPER:	DAY PHONE:
	EVENING PHONE:
	MOBILE PHONE:

INSURANCE INFORMATION: PLEASE FILL OUT INFORMATION BELOW OR ATTACH A COPY OF THE FRONT AND BACK OF THE INSURANCE CARD. ALSO, IF YOU HAVE A PRESCRIPTION CARD, PLEASE ATTACH A COPY OF FRONT AND BACK.

INSURANCE HOLDER'S PERSONAL INFO		INSURANCE COMPANY INFORMATION	
NAME		COMPANY	
SSN		ADDRESS	
ADDRESS (IF DIFFERENT THAN CAMPERS)		CITY	STATE
CITY	STATE	INS. CO. PHONE #	
ZIP		GROUP#	
EMPLOYER		ID#	

PARENT/GUARDIAN AUTHORIZATION:

I am/we are in favor of the above person attending camp and participating in all activities unless otherwise specified. As parent(s) or legal guardian(s) we accept the conditions stated, including the release of the Conference and Camp Management from liability in case of accident/injury. **Initials:** _____

IN CASE OF MEDICAL ILLNESS OR INJURY, I hereby give permission to the camp to obtain proper medical care for the camper named on this health form. I authorize the camp nurse or certified first aid care provider to give first aid care, medicine, or treatment as ordered by the camp physician. **Initials:** _____

IN CASE OF MEDICAL EMERGENCY or in the event that the named camper needs medical care beyond camp facilities, I/we understand that every effort to reach the parent(s), guardians(s) or friend listed will be made. If no one can be reached, I/we hereby give permission to the attending physician to hospitalize, secure proper treatment for, order injection, anesthesia or surgery as necessary for the camper named on this health form. **Initials:** _____

Signature: _____ Date: _____

HEALTH FORM (Please photocopy and create one form for each camper)

NAME:		EVENT#	
AGE:	HEIGHT:	WEIGHT:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE

- Does the camper have any of the following conditions?
- ADD ADHD Behavior Problems
 - Anemia currently
 - Asthma other Lung Disease
 - Bed Wetting Frequent Urinary Infections
 - Diabetes
 - Ear Infections Tubes in Ears Currently
 - Eating Disorders Anorexia/Bulimia Obesity
 - Epilepsy Absence Spells Grand Mall Seizures
 - Hay Fever/Seasonal Allergies
 - Hypertension Heart Disease
 - Mental Health Concerns Anxiety Disorder
 - Depression Bipolar Disorder
 - Menstrual Concerns LMP prior to camp ___/___/___
 - Sleep Walking Sleep Talking
 - Sprains, Strains, Muscle, Bone or Joint Problems
 - Stomach problems Diarrhea Constipation
 - Other diagnosis or concerns: _____

Explain conditions checked above including duration of condition, severity and treatments:

Surgeries/Serious Injuries: Please List with Date.

- Allergies:**
- Epi Pen usage
 - Insect/Bee Stings
 - Serious/Life threatening reaction
 - Localized swelling or redness at site
 - Medication Allergies
 - Serious/Life threatening reaction
 - Hives, rash, diarrhea, other
 Please list Med Allergies: _____
 - Food Allergies
 - Serious/Life threatening reaction
 - Cramps, diarrhea, hives
 Please list Food Allergies _____
 - Other Allergies: _____

IMMUNIZATION HISTORY: Does student attend public school & is fully vaccinated? _____

Covid 19: vaccinated? (Y/N) _____; MMR _____; Chicken Pox: _____ Tetanus _____

CURRENT MEDICATION AND INHALERS: (Add additional page if needed)

Drug Name	Dosage	Time of day to be administered

List any special dietary concerns at camp: _____

List any treatments needed at camp: _____

Has the camper been exposed to a communicable disease in the last 21 days? yes no
 If yes, what? _____ when? _____

Has the camper had any fever or persistent cough in the last two weeks? yes no
 Campers might participate in high level activities such as for hiking, running, or swimming.

Do you have reservations about your camper's ability to meet these standards?
 Yes, I have concerns No, I do not have concerns

Camper's Family Physician: _____ Telephone: _____

Parent's Signature: _____ Date: _____