Lakeside Medical Form

Name of Church:	
Participant's Name:	
Date of Birth:	**Sex:** □M □F
I will be attending week: □ Sr. High Wk 1 □ Sr. High Wk 2 □ 345 Family Camp □ Junior High	
I will be: □ Youth □CIT (College – Age 23) □ Sr. Counselor (24+)	
Camp Youth Leader's Name:	**Camp Youth Leader's Phone:**

Home Address:	
Parent/Guardian:	**Email Address:**
Day Phone:	**Cell Phone:**
If not available, in an emergency, notify:	**Relationship:**
Cell Phone:	

Name of Insurance Company:	**Group Number:**
Family Physician:	**Phone:**
Dentist:	**Phone:**
****Please attach a photocopy of both sides of the insurance card****	

Provide the date (approximate) at which participant has had or was exposed to communicable diseases:		
Chicken Pox:	**Measles:**	**Whooping Cough:**
Tuberculosis:	**Mumps:**	**Other:**

□ To the best of my knowledge, the participant is up-to-date on all immunization which my include, but is not limited to: Diphtheria/Pertussis (Whooping Cough – TDAP), Polio, Measles/Rubella/Mumps (MMR), Haemophilus Influenza (HIB), Varicella (Chickenpox) that are required for school.
Date of Last Tetanus:
Does camper take any medications: □Yes □No

Med 1:	**Reason for taking:**
Dosage:	**Specific time(s) taken:**

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Dosage:	**Specific time(s) taken:**

****All prescription drugs must be in the container in which they were issued (with medical orders and physician's name intact). Please only bring what you will need while at Lakeside. JR High Participants must bring medication to the medical staff when checking in.**

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Church Name: _____ **Participant Name:** _____

Check below if the participant is subject to any of the following conditions:

☐ Asthma Controlled ☐ Yes ☐ No	☐ Bronchitis	☐ Cramps	☐ Fainting	☐ Heart Trouble	☐ Seizures	☐ Sore Throat
☐ Athlete's Foot	☐ Constipation	☐ Diabetes Last A1C:	☐ Frequent Colds	☐ Home Sickness	☐ Sinusitis	☐ Sleep Walking
☐ Bed Wetting	☐ Convulsions	☐ Ear Infections	☐ Headaches	☐ High Blood Pressure	☐ Kidney Issues	☐ Mental Health

Explain the above information and describe any past or current physical, mental, treatment, or special restrictions or considerations while at Lakeside:

Description of any camp activities which participant should be exempted due to health reasons:

Can the participant swim? ☐ **Yes** ☐ **No**

Is the participant a vegetarian? ☐ **Yes** ☐ **No**

Dietary Restrictions:

Allergies:

Epi Pen ☐ **Yes** ☐ **No**

*****Participant must carry Epi-Pen and/or rescue inhalers with them AT ALL TIMES while at Lakeside*****

Check medication(s) that the participant <u>MAY NOT</u> receive, if deemed necessary, and be administered by Lakeside For Youth health professional. Generic or equivalent medications may be provided:

☐ Acetaminophen (ex: Tylenol)	☐ Antiseptic Spray	☐ Caladryl Lotion or spray	☐ Ibuprofen (ex: Motrin)
☐ Aloe, Solarcaine, Zinc	☐ Antibiotic Ointment	☐ Decongestant (ex: Sudafed PE)	☐ Laxative
☐ Antacids (ex: Tums)	☐ Antifungal	☐ Diarrhea Medicine (ex: Imodium	☐ Swimmer's Ear - Alcohol
☐ Antihistamine (ex: Benadryl, Claritin)	☐ Cough drops, Chloraseptic lozenges, spray	☐ Hydrocortisone Cream	☐ Visine

<u>THIS BOX MUST BE COMPLETED FOR CAMP ATTENDANCE:</u>

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted.

In consideration of the opportunity for myself, or my child, to participant at Lakeside for Youth, I acting for my child, myself and respective heirs, executors agree to assume any and all risk associated with this activity and do hereby release, indemnify and hold harmless Lakeside For Youth and respective staff from any and all liability, damage, and/or claim of any nature resulting from or arising out of my, or my child's, participation in this program and its activities.

I give permission to the medical staff to administer over the counter medications as deemed appropriate according to the participant's complaints or condition. The dosage or application will be given as directed on the labels of each medication, and may be generic equivalent.

Authorization for Treatment: In case of serious illness or injury of my child, I understand that I will be notified. If I or the emergency contact cannot be contacted, I grant permission to the Lakeside medical staff to secure proper treatment, hospitalize, and/or take any other action deemed necessary for the immediate care of my child. The completed forms may be photocopied in the event of trips out of camp.

Signature of Parent/Guardian or Adult Participant/Staff:

Date: