Medical Form

Please take the time to carefully and neatly complete all sections of this form ***using black ink****. We must have a medical form on file for* ***every*** *camper* ***by the first day of camp****. Please complete BOTH pages.*

Camp Attending ______________________________

Name ______________________________ Birthdate ____ /____ /______ Male ____ Female ____

Grade Entering ______ (fall 2010) Height _____ Weight _____ Eye Color __________

Wears Glasses Yes ____ No ____ Wears Contact Lenses Yes ____ No ____

Mailing Address ______________________________

City ______________ State/Province ______________ Zip/Postal ______________

Parent/Guardian Name(s) ______________________ E-mail Address______________________

Best Way to Contact: Home (___) __________ Work (___) __________ Cell (___) __________

Emergency Contact Information

In the event of an emergency we will try to contact the parent/guardian listed above. If the parent or guardian cannot be contacted, list below (in order of priority) who we should try to contact.

These contacts should be individuals other than the parent or guardian listed above.

Contact #1

Name ____________________

Home Phone: (___) __________

Work Phone: (___) __________

Cell Phone: (___) __________

Relationship: ____________________

Contact #2

Name ____________________

Home Phone: (___) __________

Work Phone: (___) __________

Cell Phone: (___) __________

Relationship: ____________________

Contact #3

Name ____________________

Home Phone: (___) __________

Work Phone: (___) __________

Cell Phone: (___) __________

Relationship: ____________________

IMPORTANT INFORMATION !

Prescription medications MUST arrive in original container(s). All medication will be administered in the prescribed dosage only. Any medications outside of original container will not be administered.

Maranatha is not financially responsible to pay for campers' medications prescribed while at Maranatha Camp. Parents or Guardians will be notified and will be responsible to make immediate payment with the pharmacy.

Medical/Health Insurance Information

Maranatha Camp's supplemental medical insurance pays only medical expenses caused by an accident up to $10,000 within one year of accident, that is not covered by your family health plan. This means that medical expenses caused by doctor's visits for such things as flu, colds or appendicitis are the responsibility of the participant and/or their family, and are not covered by Maranatha Camp.

Do you have health insurance? Yes ____ No ____ *Please include photocopy of insurance card.*

Health Insurance Provider ______________________ Policy Number ______________

Family Doctor ______________________ Phone (___) __________

Clinic Name ______________________________

City ______________ State ______________ Zip ______________

*****A photocopy of your insurance card MUST accompany this Medical Form.*****

over please»

Medical History

Medication Allergies ______________________________

Food Allergies ______________________________

Environmental Allergies ______________________________

☐ No known Allergies   Vaccinations recieved for 2010 ☐ H1N1 ☐ Influenza

Please check on the list below all conditions that the participant has a tendency towards:

___ asthma	___ convulsions	___ nervousness	___ stomach problems
___ diabetes	___ physical handicap	___ hyperactivity	___ Other *please list*
___ epilepsy	___ bed wetting	___ hay fever	______________
___ seizure disorder	___ earaches	___ homesickness	______________
___ heart condition	___ insomnia	___ sleepwalking	______________

List any recent illnesses, accidents or surgery, as well as the dates and current status of the illness, accident or surgery:

____

____

____

Does the participant take any medications on a daily basis? Yes ___ No ___

Has his/her medication changed in the last 14-30 days? Yes ___ No ___

Has his/her dosage changed in the last 14-30 days? Yes ___ No ___

Will the participant need any medications while he/she is at camp? Yes ___ No ___

If you checked yes, please list all the medications and time of day they need to be taken. ***Please note that <u>all</u> prescription medications must arrive at Maranatha Camp in their <u>original containers</u>, and will be administered per the doctor's prescription.***

Medication	***Dose***	***Directions (ex. 2xday, etc.)***	***Time (s)***

In addition to prescribed medications, please check all of the following over-the-counter medications that the participant is authorized to receive while at camp. Please note that <u>only</u> medications that have been authorized will be administered while the participant is at camp.

___ Acetominophen ___ Ibuprofen ___ Stomach Antacid ___ Decongestant ___ Antihistamine

___ Other OTC meds ______________________________

Dietary Restrictions

____

____

Activity Restrictions

Please indicate any restrictions for your child.

___ Swimming Restrictions: ______________________________

___ Activity Restrictions: ______________________________

Parental Consent

I certify that the above information is accurate. In the event of an emergency, I hereby give permission for the participant to receive medical treatment at the nearest hospital or clinic. I expect to be contacted as soon as possible, should this happen. If I choose not to provide Maranatha Camp with the necessary information, such as serious medical conditions or allergies, I will not hold Maranatha Camp and/or camp personnel liable for any injury or death that could occur to the participant as a result of the lack of this information.

______________________________   ______________________________

Participant's Signature   Date   Parent/Guardian Signature (if under 19)   Date

Please return to Maranatha Camp:

16800 E. Maranatha Rd. Maxwell, NE 69151 Phone (308) 582-4513 Fax (308) 582-4516 camp@maranathacamp.org

www.maranathacamp.org