Aldersgate Evangelical Center

MEDICAL FORM

All information must be filled in by the parent or guardian. The intent of this medical information is to provide Camp Aldersgate staff with the background to provide appropriate care to the camper. Please keep a copy for your records. If there are any changes to the information or status please let us know at registration.

CAMPER's NAME: _____

BIRTH DATE: _____ SEX: _____ M / F _____

FAMILY DOCTOR: _____ DR's PHONE _____

Insurance Information:

Is the camper covered by medical / hospital insurance: Yes No

Carrier or Plan Name _____

Name of Insured _____ Relationship to camper _____

Insurance Identification # _____ Group# _____

Address of Carrier (from back of card) _____

Attach copy of insurance card (front and back)

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

Name & Relationship: _____

Home Phone _____ Work Phone _____ Mobile _____

Parent / guardian signature: _____ Date: _____

Specific Medical Information:

Allergies and allergic reactions (medications, foods, plants, insects, etc.) Please list.

Having reviewed the program and activities

____ I feel the camper can participate without restrictions.

____ I feel the camper can participate with the following restrictions or adaptations. Please describe.

You should be aware of these special medical conditions of my child:

Medications: List all medications (including over the counter or non-prescription drugs). Bring enough medication to last the time of camp keeping IN THE ORIGINAL PACKAGING / BOTTLE that identifies the camper's name, prescribing physician's name of the medication, the dosage and the frequency of administration. We are unable to accept medications not in original packaging. (Use the back of form to list additional meds.)

Medication	Reason for taking	When given / frequency	Dosage given	Method given

Parent / Guardian Signature: _____ Date: _____