APPLICATION AND HEALTH RECORD

Silver State Baptist Youth Camp • P.O. Box 181 • Sedalia, Colorado 80135 • (303) 688-3420

*Application and health record **MUST** be filled out completely and signed by all campers, including adults.*

Church *Hillcrest Baptist Church* Pastor *Joe Dickinson* Date s Attending *June 12 - 16, 2017*

Name ____ Age ____ Boy ____ Girl ____ Date of Birth ____

Address ____ Phone ____

City ____ State ____ Zip ____

Address of Parent ____ Phone ____

In case of emergency, I hereby give my permission to the director of the Silver State Baptist Youth Camp to arrange for such medical, surgical or hospital care for my son, daughter or ward (child's name) ____ as may be necessary incidental to illness or injury occurring or notice of which arises while my son, daughter or ward is a camper at the Silver State Baptist Youth Camp. I further give permission for my son, daughter or ward to engaged in, supervised camp activities either on or off of the campground. I further hereby give permission to such physician or surgeon as the director may obtain, to carry out such medical, surgical or hospital procedures on my son, daughter or ward as in the opinion of such physician or surgeon may be indicted under the then existing circumstances. I understand that Silver State Baptist Youth Camp's insurance is **SECONDARY** accident insurance and it does **not** cover pre-existing conditions.

The above camper has permission to participate in all camp activities except as noted by me and/or the examining physician. I give permission to the physician selected by Silver State Baptist Youth Camp to order x-rays, routine tests, and treatment for the health of my child. If I cannot be reached in a medical emergency, I give permission to the physician selected by SSBYC to hospitalize, secure proper treatment for, and order injection, anesthesia, and/or surgery for my child. I also affirm that the information on this medical form is both complete and correct.

Medical Insurance Company ____ Policy No. ____

Group # ____ Address of Ins. Co. ____ Phone # ____

Family Doctor's Name ____ Address ____ Phone ____

____ X ____

Date ****Signature of Parent , Guardian or Adult Camper****

PERSON AUTHORIZED TO TAKE CHILD FROM CAMP:

Name: ____ Address ____

City ____ State ____ Phone Number ____

Person Unauthorized to Take Child From Camp: ____

Person to be contacted in case of emergency (other than parent)

Address ____ Phone ____

Father's and/or Mother's place of employment (No PO Box)

Name ____

Address ____ Phone ____

Name ____

Address ____ Phone ____

ACTIVITY RESTRICTIONS: I do not want my child to participate in the following activities: ____

HEALTH RECORD: (Must be filled out or cannot attend SSBYC or attach copy of physical)

Physician's Name ____ Doctor Phone ____ Doctor Fax ____

Date of Last physical examination within 24 months of camp ____

This child is planning to attend a residential camp away from his/her home and may be distant from medical care. (The camp has a nurse on duty at all times.) Your response to these questions will help in the care of the child.

Significant medical history (physical,serious injuries, illness or lacerations, learning, and/or psychological concerns) ____

If camper is on medication, *Medication Form* MUST be completed. Only list medication camper takes during the summer. Medication not listed will NOT be administered. Exception would be over the counter medications on camp doctor's standing orders.

Immunization Records: Attach certificate of immunization or complete the following:

Tetanus-Diphtheria(DT) ____ Diphtheria-Tetanus-Pertussis(DPT) ____ Polio ____

Hepatitis B ____ Measle-Mumps-Rubella(MMR) ____ Other ____

Drug Allergies: ____

Food Allergies: ____

I, the examining physician, hereby authorize the properly qualified health personnel of Silver State Baptist Youth Camp to administer the medications prescribed for the above camper. I have examined this person and found him/her to be in satisfactory condition and capable of active participation in a regular camp program with exception: ____

****Signature of physician or nurse practitioner** (RN not acceptable) ____

Physician's name ____ Phone ( ) ____ Date ____

Address ____ City ____ State ____ Zip ____

(PLEASE FILL OUT **BOTH** SIDES OF THIS APPLICATION)