MEDICAL/AUTHORIZATION FORM – PENIEL BIBLE CAMP

Please mail this form to: **Peniel Bible Camp (c/o Nurse), 3260 State Route 314, Fredericktown, OH 43019**
OR bring this form to camp with the named individual.

CAMPER INFORMATION

NAME:
DATE OF BIRTH:
ADDRESS:

EMERGENCY CONTACTS

NAME/RELATION: _____/_____
PHONE: (_____)_____
NAME/RELATION: _____/_____
PHONE: (_____)_____

PRE-EXISTING MEDICAL CONDITIONS □ None
(Include pertinent medical history - seizures, asthma, allergies, etc.)

_____
_____
_____
_____
_____
_____
_____

Last Tetanus Vaccine :

DRUG ALLERGIES (med & reaction) □ No known drug allergy

_____
_____
_____

ACTIVITY RESTRICTIONS: □ None

_____
_____
_____
_____

DIETARY ALLERGIES: □ None

_____
_____
_____
_____

MEDICATIONS (med name, dose, & frequency) □ Takes no medications

1._____ □Breakfast □Lunch □Dinner □Bedtime
2._____ □Breakfast □Lunch □Dinner □Bedtime
3._____ □Breakfast □Lunch □Dinner □Bedtime
4._____ □Breakfast □Lunch □Dinner □Bedtime
5._____ □Breakfast □Lunch □Dinner □Bedtime
6._____ □Breakfast □Lunch □Dinner □Bedtime

****NOTE: Please send camper's medication(s) in the originally labeled container.** Attach additional page if needed for additional medications.

OVER THE COUNTER MEDICATIONS AVAILABLE THROUGH CAMP NURSE :

Cross out medications you do NOT want your child to receive, in the event he/she receives medical attention.

Acetaminophen(Tylenol)	Dextromethorphan (cough suppressant)	Bacitracin (Neosporin)
Ibuprofen (Motrin)	Diphenhydramine (Benadryl)	Cetirizine (allergy medication)
Gauifenesin (expectorant)	Phenylephrine (Sudafed)	Bismuth (PeptoBismol)

INSURANCE COMPANY: _____ **POLICY HOLDER:** _____ **GROUP #:** _____ **POLICY ID**: _____

This form is correct and accurately reflects the health status of the camper. The above camper has permission to participate in all camp activities except as noted. I give permission to the medical staff as selected by Peniel Bible Camp (PBC) to evaluate and treat my child for minor illnesses and injuries. I understand I will be contacted if there are any concerning conditions that may require a higher level of care. If I cannot be reached in an emergency, I give my permission to PBC staff to secure proper treatment for my child as medically appropriate.

Additionally, I give permission for PBC to take and use photos that include this individual in camp publicity.

Signature of Guardian: _____ Relationship to camper: _____ Date: _____
(or individual if 18+ yrs old)

For office use beyond this point:

_____
_____
_____

CAMPER VISITS TO CAMP NURSE

(e.g. 6/15/2021 10AM : camper complained of headache. Acetaminophen 325mg given)
