Camp Sonlight Health Form

Ministry of Victory Baptist Church - P. O. Box 160 - Vergennes, Vermont 05491

THIS HEALTH FORM MUST BE COMPLETED AND RETURNED BEFORE AUGUST 1, 2017

Personal Information

Name _____ Age _____ DOB ____/____/____ Gender _____
Mailing Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____Emergency Phone _____

Camping Information. Attended Camp Sonlight before _____ Yes _____ No Years Attended _____

Allergies. Please list any medicine, food or environmental allergies. _____
_____ Is epipen required: _____ Yes _____ No

Medical History. Check all that apply. Please provide information for every checked item.

____Asthma ____Skin Problems ____Stomach Problems ____Heart Problems
____Convulsions/Epilepsy ____Bed-wetting ____Sleepwalking ____Kidney Problems
____Chronic Illness ____Emotional/Behavioral Problems

Immunizations. Date of last tetanus shot: _____Are other immunizations up to date? _____ Yes _____ No

Over-the-counter medications. Cross out the medications you DO NOT wish your child to receive from the nurse.
Tylenol Ibuprofen Benadryl Hydrocortisone cream Antibiotic ointment

Guardian signature: _____

Supplement information for checked items, other comments (use back of form if necessary): _____
_____

Medications (please list): _____
_____
_____
_____

Note: All medications, including prescription, over-the-counter, vitamins and/or supplements **MUST** be given to the camp medical staff upon arrival at Camp. The medication must be provided in the original container with dosage amount and time and camper name clearly printed. In case of medical or surgical emergency or illness, I give my permission for a licensed healthcare provider to give proper treatment to the person named above. I also authorize the camp medical staff to administer medications and treatments as necessary. (If 18+ years of age, you may sign your own form).

Printed Name _____ Phone _____

Parent/Guardian Signature _____ Date _____

Medical Examination

Medical examination must be completed within 24 months of last day attending camp. It must be completed by a medical doctor (MD), registered nurse practitioner (ARNP), or physician's assistant (PA). Complete the following or attach a completed medical examination form.

Date of Examination _____ Phone _____
Findings relevant to patient attending a summer camp program: _____
_____

Examiner's Signature _____ Date _____