

STAFF/CABIN LEADER MEDICAL INFORMATION

NAME _____

CHECK AND COMMENT ON ALL THAT APPLY:

ALLERGIES:

Penicillin Bee/insect sting Sulfa/other drugs Poison Ivy
 Sunburn easily Tetanus shot Hay fever Aspirin/Tylenol
 Other (list) _____

HAS HISTORY OF/UNDER MEDICAL CARE FOR:

Heart trouble Tonsillitis Asthma Epilepsy/seizures
 Appendicitis Hernia Bronchitis Diabetes
 Nervous disorder Athletes foot Stomach ulcer Skin disorder
 Other (Explain) _____

SUBJECT TO:

Cramps Convulsions Sore throat Headaches
 Nosebleeds Earaches Fainting Toothaches
 Swimmer's ear Cold/pneumonia Stomach/digestive disorders
 Other (Explain) _____

MEDICATIONS REQUIRED WHILE AWAY FROM HOME

Name of Medication _____

For _____

Instructions _____

(All medications should be checked in with the camp nurse and in the original container.)

Any medications that you CANNOT TAKE? _____
(aspirin, cough drop, etc.)

FAMILY PHYSICIAN _____ PHONE (_____) _____

NAME OF INSURANCE CARRIER _____

POLICY # _____ MAILING ADDRESS _____

MEDICAL RELEASE: I have provided complete and accurate information about myself and understand that, in the event medical treatment is required, and I cannot speak for myself, every effort will be made to contact the person listed in case of emergencies. However, if they cannot be reached & I cannot give my permission, permission is given to the staff to secure the medical services deemed necessary to provide for my well being. I also understand that the insurance provided by Grand Oaks Baptist Assembly, Inc. is a limited supplemental policy covering only injury or accidents occurring during the event at Grand Oaks, and will also be used only to supplement the family insurance.

I HAVE ALSO READ AND UNDERSTOOD THE INFORMATION SHEET PROVIDED WITH THIS FORM AND AGREE TO ITS CONTENTS. LIKEWISE, I HAVE APPROVED THE BACKGROUND CHECK CONDUCTED BY MY CHURCH.

Signed _____

Date ____/____/____