FLS CAMP – ADULT MEDICAL RELEASE FORM

SUMMER CAMP ATTENDING: _____ DATE OF CAMP ___/___/____ THRU ___/___/___

CAMPER NAME: _____ DOB: ____/_____/_____

First Middle Last

AGE: _____ SEX: Male or Female

CHURCH: _____ CITY: _____ STATE: _____

PERSON TO NOTIFY IN EVENT OF EMERGENCY: _____

RELATIONSHIP TO CAMPER:_____

PHONE NUMBER OF CONTACT PERSON: CELL: (_____) _____

IF UNABLE TO REACH ABOVE PERSON: Notify: _____

Relationship to Camper: _____

PHONE NUMBER OF CONTACT PERSON: CELL: (_____) _____

FAMILY PHYSICIAN:_____ PHONE: (_____)_____

MEDICAL INSURANCE:_____

PLAN OR GROUP #:_____ (Attach a copy of card)

POLICY HOLDER: _____

POLICY HOLDERS DATE OF BIRTH: ____/_____/_____

Medical Information

Significant Allergies (specify)

- ☐ Food:_____
- ☐ Insect Sting:_____
- ☐ Medicine/Drug:_____
- ☐ Plant/Pollen:_____
- ☐ Other:_____
- ☐ Special Diet:_____
- ☐ Recent Surgery?_____

Diseases, Chronic or Recurring Illness: (Check all that apply, explain)

- ☐ Asthma:_____
- ☐ Bleeding Disorder:_____
- ☐ Dermatological Condition:_____
- ☐ Diabetes:_____
- ☐ Ear Infections:_____
- ☐ Heart Defect:_____
- ☐ Seizures:_____
- ☐ Stomach Condition:_____

State law requires all medications to be placed in the campus Health Center. All medications must be brought in the original container (prescription or over the counter) properly labeled as prescribed by law. Prescription labels must have the camper's name and current dosage. A current Medication Administration Authorization Form MUST accompany all medication(s). Medications and Administration instructions will be collected and reviewed by FLS Medical staff upon camper arrival. FLS Medical staff requests that you NOT send over the counter medications such as Tylenol, Ibuprofen, Benadryl, or antihistamines. FLS stock an assortment of over-the-counter medications for the occasional need.

Health Care and Camp Permission

All adults must **INITIAL & SIGN** the statements below.

_____ I give my permission for first aid techniques and simple health care to be administered as the need arises. I understand in the event of any serious injury or illness, the camp officials reserve the right to seek professional medical attention including but not limited to consultation with medical director, EMS transportation, and hospitalization.
_____ I give permission to consultation with the Camp Health Supervisor and/or the medical director's standing orders to be given the following medications as indicated by checking below.

_____acetaminophen (i.e. Tylenol)	_____ Ibuprofen (i.e. Advil)	_____ decongestant (i.e. Sudafed)
_____ antihistamine (i.e. Benadryl, Claritin)	_____ antihistamine cream	_____ antibacterial ointment
_____ antacid tablet (i.e. Tums)	_____ additional medications as indicated/prescribed by the FLS Medical Director	

I hereby attest that all information listed on this Medical Form is complete and accurate to the best of my knowledge that I am in acceptable health, physical ability, and emotionally ready to fully participate in camp. I agree to participate in all activities associated with the enrolled event with the exceptions of those that are noted.

I, _____Give my permission to FLS Camp and Conference Center's management, medical staff, and/or the group director to provide medical treatment that may be deemed necessary to insure my well-being. I, the undersigned, do hereby release and forever discharge all from any and all claims, demands, actions or cause of action arising out of damage or injury while participating in FLS Camp sponsored activities.

X_____ _____

Adult Sponsor/Leader Signature Date