MEDICAL FORM

Conference/Retreat Name CHILTON BAPTIST ASSOCIATION Kid's Camp *Date* July 23-27, 2012

Guest Information

Name ______________________ Birth Date __________ Age ______ Sex (M/F) ______

Address ______________________ City __________ State ______ Zip ______

Phone: Daytime __________ Evening __________ SS # (Optional) __________

Church ______________________ City __________ State ______ Zip ______

Emergency Contact

Parent/Guardian ______________________

Address ______________________ City __________ State ______ Zip ______

Phone:
Daytime __________ Evening __________ Cell __________

Health History

Please indicate any physical conditions that might limit your participation in any programs. This information may not exclude you from participation but gives imperative information to protect your health and safety. If you are unsure of any health issues please discuss this with your group leader.

Please list and give a brief but detailed description of any such condition:

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Immunizations current? ______ If no explain ______________________

Date of Last Tetanus Shot __________ Date of Last TB Skin Test __________

Name of Family Physician __________ Address & phone __________

Medical Insurance

CompanyName ______________________

CompanyAddres ______________________

Company Phone __________ Group # __________ Contract __________

PrimaryInsured/PolicyHolder ______________________

Address ______________________ Daytime Phone __________ Evening __________

I hereby give permission to the medical personnel selected by CHILTON BAPTIST ASSOCIATION to provide routine health care; to administer medications; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by CHILTON BAPTIST ASSOCIATION to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips off campus.

Signed: ______________________ Date: __________

I hereby give permission for CHILTON BAPTIST ASSOCIATION to administer over-the-counter medications if CHILTON BAPTIST ASSOCIATION deems it necessary. Dosages will be administered according to directions on the bottle unless a physician directs otherwise.

Signed: ______________________ Date: ______