


# PROGRAM HEALTH AND CONSENT FORM

Camp Attending:  **Miracle  Ranch**  
 ** Island Lake**

Event Attending: \_\_\_\_\_

Dates: \_\_\_\_\_

**TO BE COMPLETED FOR ALL PERSONS USING CAMP:**

Camper Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_  
Parent/guardian: \_\_\_\_\_ Parent/guardian-Date of birth: \_\_\_\_\_  
Home address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_  
Work phone: (\_\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_  
Emergency contact: \_\_\_\_\_ Emergency phone: (\_\_\_\_\_) \_\_\_\_\_  
Primary doctor: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
Health insurance provider: \_\_\_\_\_ Group policy #: \_\_\_\_\_  
Policyholder: \_\_\_\_\_ Policyholder's #: \_\_\_\_\_

**Please include a photocopy of all health insurance cards (front and back) with this application form.**

**ARE YOU SUBJECT TO ANY OF THE FOLLOWING? (please explain below)**

<b>ALLERGIES</b>	<b>PHYSICAL</b>			
___ Medication	___ A.D.D. or A.D.H.D	___ Diabetes	___ Homesickness	___ Special diet
___ Food	___ Asthma	___ Dizziness	___ Hypertension	___ Sunburn
___ Hay fever	___ Bed wetting	___ Eating disorder	___ Kidney problems	___ Swimmer's ear
___ Insect sting	___ Bleeding/clotting problems	___ Frequent colds	___ Psychiatric treatment	
___ Other	___ Bronchitis	___ Frequent ear infections	___ Sinusitis	
	___ Convulsions	___ Heart disease	___ Sleepwalking	___ Other: _____

Specifics: \_\_\_\_\_

Treatment for allergic reaction: \_\_\_\_\_

**IMMUNIZATIONS** - please give approximate immunization dates for:

Tetanus: \_\_\_\_\_ Mumps: \_\_\_\_\_ Measles: \_\_\_\_\_ Chicken Pox: \_\_\_\_\_

Describe any current conditions requiring medication, treatment or special restrictions while at camp (if none, please indicate). \_\_\_\_\_

Describe any past medical conditions which might require special attention (if none please indicate).  
\_\_\_\_\_

Are you on medication? \_\_\_\_\_

**ANY MEDICATION BROUGHT TO CAMP MUST BE ACCOMPANIED BY WRITTEN INSTRUCTIONS FROM A PHYSICIAN/PARENT AND IS TO BE GIVEN TO AND ADMINISTERED BY THE CAMP NURSE. ALL PRESCRIPTIONS MUST BE BROUGHT TO CAMP IN THE ORIGINAL CONTAINER IN WHICH THEY WERE ISSUED (WITH MEDICAL INSTRUCTIONS AND DOCTOR'S NAME INTACT). OTHER CONTAINERS WILL NOT BE ACCEPTED. NOTE: Do not bring medication (Asprin, Tylenol, Advil, cold remedies, Pepto Bismo, etc.) as the camp nurse will provide if needed. Medication must be given directly to the camp nurse at registration and picked up by the parent/guardian at the end of camp.**

**MEDICAL RELEASE**

I hereby give consent for my child to participate in all camp activities and receive routine and/or emergency medical care. In the event of a medical emergency, I understand every effort will be made to contact me. If I cannot be reached, I give my permission to the physician selected by CRISTA Camps & Conferences to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child.

[This Section may not apply to children who attend Camps with a Guest Group]. In order to assist parents whose child may require medical attention while at camp, CRISTA Camps & Conferences has arranged for secondary medical insurance to pay medical expenses which may remain after your primary coverage has paid. If you have a deductible or co-pay amount under your coverage, or expenses which may not be covered, CRISTA Camps & Conferences' coverage is designed to pay those fees, up to the limits of our policy. If you have no coverage for your child, CRISTA Camps and Conferences' coverage may become primary and cover the expenses up to the policy limits, if your lack of insurance is verified. This secondary medical insurance covers accidents up to \$2,500 and illnesses up to \$800.



**PARENT/GUARDIAN Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

PART OF THE CRISTA FAMILY