



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)

ALLERGIES

PHYSICAL

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

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. It 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. 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, our coverage is designed to pay those fees, up to the limits of our policy. If you have no coverage at all for your child, our insurance will verify that, and our policy will then become primary and cover the expenses up to the policy limits. Our policy covers an accident up to \$2,500 and an illness up to \$800.

PARENT/GUARDIAN Signature: _____ Date: _____

