CAMPER MEDICAL FORM

PERSONAL INFORMATION			
Camper's Last Name (Print):			Camper's FIrst Name (Print):
Age:	Height:	Weight (Lbs):	Gender: __ Male __ Female

IMMUNIZATION WAIVER

Only sign if your child has NOT been immunized.
We, the parents/guardians of _____, take full responsibility for the welfare of our child's health as have decided not to have him or her immunized. Therefore, we will not hold Resurrection Life Church or Camp Harvest responsible in this regard.

Parent/Guardian Signature: _____ Date: _____

CONSENT OF RELEASE/MEDICAL TREATMENT

I give (camper's name): _____ permission to attend Resurrection Life Church Kids Camp and to participate in all of the activities as planned in the camp program. I will not hold Resurrection Life Church, their staff or volunteers responsible in the case of an injury or illness. I give permission for trained medical personnel to provide routine medical care and/or emergency treatment to the child named above and I authorize adult camp staff personnel to transport my child if needed to a medical facility and to sign consent forms for such treatment in the event of an illness or injury. I give ResLife permission to use pictures and images generated at Kids Camp for promotional publication.

Resurrection Life Church's insurance is primary insurance

I hereby give permission to Resurrection Life Church, which is licensed by the Department of Consumer and Industry Services, to secure emergency and non-emergency medical and/or surgical treatment for the minor child named above. I further release Resurrection Life Church from all liability beyond the limits of their insurance coverage.

I (parent/legal guardian) the responsible person of this camper, certify that the information provided on this document is correct to the best of my knowledge.

Print First and Last Name:_____
Relationship to camper: _____
Parent/Legal Guardian Signature: _____ Date: _____

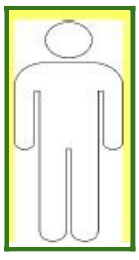
HEALTH ASSESSMENT (Please fill out this portion when you arrive at Harvest with your camper).

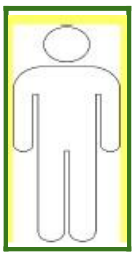
See Health Officer if there are any YES answers.

No	**Yes**	Do you have any vitamins, any over the counter or prescription medications, including medical ointments - Remove from luggage, fill out the reverse side of this document and give it to a Health Officer
No	**Yes**	Have you (camper) knowingly been exposed to any contagious disease in the last three days?
No	**Yes**	Do you (camper) have cough or cold symptoms, vomiting or diarrhea, skin rashes or infection, or fever in the last 24 hours?
No	**Yes**	Do you (camper) have any bruises or bumps we should know about? If yes, please note the location on the body diagrams.

I, the parent, have (parent) checked my child(ren) for head lice or nits within the last 48 hours.
Parent Signature:_____
Date: _____

Health Officer Notes:

Front of: 

Back of: 

CAMPER MEDICATION FORM

ALLERGIES & NOTES

For Office Use Only!

Print Last Name

Print First Name

LIST ALL MEDICATIONS (USE ANOTHER FORM IF NEEDED)

Office use only

Medication (Actual name on bottle): ______

Strength per unit & form on medication: ______

Units per dose/time of dose: (Put the amount of medication by the time of day)

____ /Breakfast ____/Lunch ____/Dinner ____/Bedtime ____/As Needed

Route:

Special Instructions:

	B	L	D	B
M				
T				
W				
T				
F				

Medication (Actual name on bottle): ______

Strength per unit & form on medication: ______

Units per dose/time of dose: (Put the amount of medication by the time of day)

____ /Breakfast ____/Lunch ____/Dinner ____/Bedtime ____/As Needed

Route:

Special Instructions:

	B	L	D	B
M				
T				
W				
T				
F				

Medication (Actual name on bottle): ______

Strength per unit & form on medication: ______

Units per dose/time of dose: (Put the amount of medication by the time of day)

____ /Breakfast ____/Lunch ____/Dinner ____/Bedtime ____/As Needed

Route:

Special Instructions:

	B	L	D	B
M				
T				
W				
T				
F				

Medication (Actual name on bottle): ______

Strength per unit & form on medication: ______

Units per dose/time of dose: (Put the amount of medication by the time of day)

____ /Breakfast ____/Lunch ____/Dinner ____/Bedtime ____/As Needed

Route:

Special Instructions:

	B	L	D	B
M				
T				
W				
T				
F				

Medication (Actual name on bottle): ______

Strength per unit & form on medication: ______

Units per dose/time of dose: (Put the amount of medication by the time of day)

____ /Breakfast ____/Lunch ____/Dinner ____/Bedtime ____/As Needed

Route:

Special Instructions:

	B	L	D	B
M				
T				
W				
T				
F				