

New Life Family Church - Youth Camp Medical Form

Participant Information:

Full Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Parent/Guardian Name: _____

Parent/Guardian Phone: _____

Emergency Contact (other than parent/guardian):

Name: _____

Relationship to Participant: _____ Phone: _____

Medical History:

1. Does the participant have any known allergies (e.g., food, medication, insect bites)? If yes, please provide details:

2. Does the participant have any dietary restrictions or special dietary needs? If yes, please provide details:

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3. Has the participant ever been diagnosed with or had treatment for any of the following medical conditions? (Please check all that apply)

- ☐ Asthma
- ☐ Diabetes
- ☐ Epilepsy/Seizure Disorder
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Mental Health Conditions (e.g., anxiety, depression)
- ☐ Chronic Illness (please specify): _____
- ☐ Other (please specify): _____

4. Is the participant currently taking any medications? If yes, please provide details, including medication names, dosage, and frequency:

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5. Has the participant had any surgeries or significant medical procedures in the past? If yes, please provide details:

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6. Is the participant up to date with their immunizations? If no, please provide details:

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7. Has the participant experienced any recent illnesses, injuries, or hospitalizations? If yes, please provide details:

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8. Are there any other medical conditions or concerns that we should be aware of? If yes, please provide details:

Insurance Information: Insurance Provider: _____

Policy Holder Name: _____

Policy Number: _____

Consent and Release: I, the undersigned parent/guardian of the participant named above, hereby authorize the staff of New Life Family Church Youth Camp to provide routine health care, administer necessary medication (as described above or as directed by healthcare professionals), and seek emergency medical treatment if required. I understand that every effort will be made to contact me in the event of a medical emergency. However, if I cannot be reached, I hereby give permission to the physician or healthcare provider selected by the camp staff to hospitalize, secure treatment for, and order injections, anesthesia, or surgery for the participant named above. I agree to assume all financial responsibility for any medical treatment provided.

Parent/Guardian Signature: _____ Date: _____

Please attach a copy of any additional medical documents or instructions that may be relevant.

Note: It is important to provide accurate and up-to-date information on this form. Notify the camp staff promptly of any changes in the participant's medical condition or medication during the camp period.