

Pine Bush Bible Camp- Campers and Minor Staff Medical Report

Name _____ Date of Birth _____ Home Phone _____
Cell Phone (Mother) _____ (Father) _____
Work phone (Mother) _____ (Father) _____
Address _____ City _____ State _____ Zip _____

IN CASE OF EMERGENCY and the Parent or Guardian is not available NOTIFY:

Name _____ Phone (home) _____ (work) _____
(cell) _____ Address _____

Has the camper had any of the following:

- Rheumatic Fever Epilepsy Severe Earache Sickle Cell Convulsion Hernia
 Kidney Disease Skin Disease/Eczema Heart disease Cerebral Palsy Lung Disease
 Diabetes Chicken Pox

Does the camper now have any of the disease above (or any other medical condition)? YES NO

If yes, please explain _____

Has the camper had any operations? YES NO If yes, what operation and when?

Does the minor have any of the following allergies:

- Hayfever Bee Sting Serious Ivy, oak or Sumac poisoning Medication _____
 Asthma (must bring medication) Other _____

If yes, please indicate the severity of the reaction, the date and treatment used: _____

Does camper have frequent:

- Sore throats Sinus trouble Constipation Sleep walking Nose Bleeds Bed wetting
 Bronchitis Upset Stomach Fainting spells

For female campers:

Has this person menstruated? YES NO If not, has she been told about it? YES NO

If yes, is her menstrual history normal? YES NO Special consideration _____

List any Dietary or Activity restrictions _____

List any other information we should be aware of _____

Immunization Record: (Please attach a copy of the immunization record or indicate the most current booster)

DPT _____ MMR _____ Polio _____ Varicella _____ Hept B _____ HIB _____

Meningococcal meningitis _____

Mantoux _____ Results negative positive If positive, please indicate date of chest x-ray and results _____
and any treatment received _____

Note: Our medical insurance has limitations based upon your family's medical insurance coverage. Any medical cost incurred while at PBBC that is in excess of \$100 must be submitted to your medical insurance carrier for payment. If there is any portion of the cost unpaid by your medical insurance carrier, those costs will then be submitted to the camp's medical insurance carrier. **Please list Personal Insurance Coverage Name and policy number or Medicaid number:** _____

Release for medical treatment (must be signed by a parent/guardian).

I hereby grant permission to the staff members of Pine Bush Bible Camp to obtain proper medical diagnosis and treatment for my child by a qualified doctor or hospital in case of sickness or injury while at camp.

Signature: _____ Date: _____