2025 SUMMIT CAMP MEDICAL RELEASE

Please complete this form so we can provide proper care for your student at camp.
A completed health form is required for all Summit Camp activities.

SECTION I - BASIC CONTACT INFORMATION

Name: _____ **Birthdate**:___/___/_____ **Age**:_____

Home Address: _____
Street City State ZIP

Social Security #: _____ **Gender**: M F

Camper Lives With: Mother & Father Mother Father Grandparent Other _____

Custodial Parent/Guardian: _____ Phone: ( )_____

Home Address: (if different) _____
Street City State ZIP

If not available in an emergency, please notify: _____

Relationship: _____ **Phone**: ( )_____

Family Physician Name _____ **Phone**: ( )_____

Dentist/Orthodontist Name _____ **Phone**: ( )_____

SECTION II - TRANSPORTATION

In order to protect your child, please provide us with the following information:

Who will be picking your child up at Davis & Elkins College at the close of camp?
Name: _____

Is there anyone whom you do not want to pick up your child at the close of camp? If yes, please list name(s) _____

SECTION III - INSURANCE INFORMATION : Please include a copy of your insurance card and fill out the information below in the event of needing prompt health care for your child.

Is the participant covered by family medical/hospital insurance: YES NO

If so, indicate carrier or plan name: _____ Group # _____

Carrier Address: _____

Address for Claims: _____

Policy Holder's Name: _____ Relationship: _____

Policy Holder's Insurance ID #: _____ Employer: _____

Policy Holder's Social Security #: _____ Policy Holder's Date of Birth: ____/____/____

SECTION IV- MEDICATIONS AND RESTRICTIONS

Will camper be taking medications while at camp? Yes No

***Medications include prescription, over-the-counter, vitamins, inhalers, etc.*

If camper will be taking medications while at camp, please list all (prescription and non-prescription). Include the medication name, prescribing physician, physicians' phone number, and the dosage instructions. Use an additional sheet if needed. When checking in at camp, please provide all medications in their original packaging that identifies the prescribing physician (if prescription drug), the name of the medication, the dosage, and frequency of administration.

NAME OF DRUG	DOSAGE AMOUNT	TIMES GIVEN	DAILY DOSE	REASON FOR MEDICATION	NOTES:
Example: Mellaril	50 mg	8 am & 5 pm	100 mg	Behavioral	Crush pill

Identify any medications the camper takes during the school year that the camper does not/may not take during the summer: _____

Prescribing Physician : _____ Phone: ( )_____

I grant permission for the camp health director to administer:

***Please circle your choice for each over-the-counter medicine below*

Aspirin Yes No **Non-Aspirin** Yes No **NSAID** (ibuprofen/Advil, Motrin) Yes No

Cough Medicine Yes No **Benadryl** Yes No **Pepto-Bismol** Yes No

Maalox Yes No **Imodium** Yes No

Parent/Guardian Signature for over-the-counter administration _____

Special Instructions or Considerations for Minor Illness *Please provide information (past and present) on any illnesses, injuries (i.e. broken bones, concussions, asthma, etc.) or special instructions for minor illnesses. Unless specific instructions are provided, camp health care staff will treat minor illnesses with over the counter medications. If illness persists, parents will be notified.*

_____

_____

Has your child ever been put in concussion protocol? Yes No If so, when? _____

Any change to this form should be provided to camp health personnel upon camper's arrival in camp.

SECTION V - ALLERGIES

☐ Camper does not have any allergies.

Camper is allergic to:

☐ Hay Fever ☐ Poison Ivy/Oak ☐ Insect Stings ☐ Certain Foods

☐ Penicillin ☐ Other Drugs: _____

Please specify allergy and describe reaction and treatment.

_____

_____

_____

SECTION VI - AUTHORIZATION

Parent/Guardian Authorizations: This health history is correct and complete to the best of my knowledge, and the person described herein has permission to participate in all camp activities, except as noted. I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, and treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary transportation for me and/or my child. In the event I cannot be reached in an emergency, I give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp. I understand that all reasonable attempts will be made to contact me as soon as possible after a condition requiring treatment arises, and that, if I cannot be reached, all reasonable efforts will be made to contact the alternate listed above. I also understand that all reasonable precautions will be taken to ensure safety at all times. I further release the West Virginia Convention of Southern Baptists, Davis & Elkins College, and all persons associated with these organizations from any liability related to any accident, injury, or illness involving the individual named on this form.

_____ _____

SIGNATURE OF PARENT/GUARDIAN OR ADULT CAMPER/STAFFER **DATE**

_____

PRINT FULL NAME