

# SUSQUEHANNA CONFERENCE CAMP & RETREAT MINISTRY 2021 CAMP MEDICAL CONSENT FORM

*Please complete both sides and sign this medical consent form.  
The registration process is complete when the registration and medical consent forms  
are submitted via mail, fax, or e-mail. **50% deposit due by May 1.***

**NOTE: Fee balance must be paid in full 2 weeks prior to the start of your week at camp.**

**CAMP DATE** \_\_\_\_\_ **CAMP CODE** \_\_\_\_\_  
(CAMP OFFICE ONLY)

**CAMPER INFO:**

Camper's Last Name \_\_\_\_\_ First Name \_\_\_\_\_  Male  Female  \_\_\_\_\_

Birthdate \_\_\_\_\_ Best E-mail (to receive pre-camp information) \_\_\_\_\_

Camper Address (Street, City, State, Zip) \_\_\_\_\_

Home Ph ( ) \_\_\_\_\_ Grade **COMPLETED** Spring 2021 \_\_\_\_\_

Name of Parent 1/ Guardian \_\_\_\_\_ Name of Parent 2/ Guardian \_\_\_\_\_

Address (if different from camper) \_\_\_\_\_ Address (if different from camper) \_\_\_\_\_

Home Ph ( ) \_\_\_\_\_ Home Ph ( ) \_\_\_\_\_

Work Ph ( ) \_\_\_\_\_ Work Ph ( ) \_\_\_\_\_

Cell Ph ( ) \_\_\_\_\_ Cell Ph ( ) \_\_\_\_\_

Emergency Contact Person other than Parent: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Ph ( ) \_\_\_\_\_

**INSURANCE/DOCTOR INFO:**

Health Insurance Co. \_\_\_\_\_

ID/Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_

Name of Primary Care Physician \_\_\_\_\_ Ph ( ) \_\_\_\_\_

Date of last physical \_\_\_\_\_ (current) Height \_\_\_\_\_ Weight \_\_\_\_\_

List any medications the camper is currently taking

Medication	Dosage	Instructions
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____

List any food and/or drug allergies of the camper \_\_\_\_\_

What kind of reaction? \_\_\_\_\_

Are there any non-prescription medications you DO NOT want your child to receive? \_\_\_\_\_

Has camper had a tetanus shot in the past five years?  Yes  No If Yes, Date \_\_\_\_\_

Has camper ever had hepatitis?  Yes  No

Does the camper need specific behavioral and/or emotional support?  Yes  No

If yes, please describe \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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CAMP DATE \_\_\_\_\_

CAMP CODE \_\_\_\_\_

(CAMP OFFICE ONLY)

**CIRCLE THOSE THAT APPLY AND EXPLAIN AS NECESSARY**

- |                            |                      |                                |                              |
|----------------------------|----------------------|--------------------------------|------------------------------|
| ADHD                       | Bronchitis           | Eye/Vision Problem             | Learning Disability          |
| Allergies                  | Concussion           | Fainting                       | Nose Bleed                   |
| Anxiety                    | Convulsions/Epilepsy | Heart Defect/Disease           | Poison Ivy                   |
| Asthma                     | Depression           | Homesickness                   | Prior Positive COVID-19      |
| Bedwetting                 | Diabetes             | Hypertension                   | Sleep Disorders/Sleepwalking |
| Bleeding/Clotting Disorder | Ear Infections       | Insect Stings                  | Swimmer's Ear                |
| Braces                     | Ear/Hearing Problem  | Other Medical Conditions _____ |                              |

Explanation of above: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Disabilities: \_\_\_\_\_  
\_\_\_\_\_

Limitations or suggestions regarding activities: \_\_\_\_\_  
\_\_\_\_\_

Any other needs; best care practices, dietary restrictions, etc: \_\_\_\_\_  
\_\_\_\_\_

Is there any other information about the camper that we should know in seeking to best minister to their needs? (i.e. first time away from home, gender identity, recent traumatic event, etc.) \_\_\_\_\_  
\_\_\_\_\_

*If your child/youth has been taken off medications for the summer by you, the parent/guardian, we highly recommend those medications be taken during their week of camp so your child/youth will have a quality experience.*

**MEDICAL CONSENT AND AUTHORIZATION:** In the event of an emergency or non-emergency situation requiring medical treatment of the camper during their attendance at the camp, I/we, the undersigned parent(s)/guardian(s) of the camper, give the Camp Health Director my/our consent and authorization for all medical treatment that is deemed necessary by qualified medical personnel for the proper care and treatment of the camper, including but not limited to administration of first-aid, use of an ambulance, x-ray examination, administration of anesthesia, surgery and hospitalization.

Parent/Guardian Signature \_\_\_\_\_

Parent/Guardian Name (please print) \_\_\_\_\_

Relationship to the camper \_\_\_\_\_

Date \_\_\_\_\_

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***(NOTE: Fee balance must be paid in full 2 weeks prior to the event.)***

**Susquehanna Conference Camp & Retreat Ministry**  
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