STAFF HEALTH FORM AND INSURANCE INFORMATION

Office Use
_____
_____
_____
_____

March 15-17 2024

Mail – February 29, 2024

NAME: _____ Birthday _____

Sex: Male or Female **Deaf** ___ **Hearing** __ **Blood Type:** A+, A-, B+, B-, O+, O-, AB+, AB-

ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____)_____ WORK: (_____)_____

Health INSURANCE POLICY **Please include a copy of your insurance card**

Name of Policyholder:
_____

Phone Number: _____ Policy/Group # _____

Type of Coverage: _____

Doctor's Name: _____ Phone:(_____)_____
Address: _____
Last date of your Tetanus shot? _____

ALLERGIES: *Please use X if you have.*

Bee sting	Poison Ivy	Penicillin	Poison Oak	Sumac	Mold	Dust

Do you use? Please use X in box if you have.

Epi-Pen	*Inhaler*	*CPAP Machine*	*Nebulizer*

Please Circle YES or NO

Do you have sensitive skin? YES NO

Sunburn easy YES NO

Do you have eczema YES NO

Medication or Insulin

Medicine Name	Dose	How often medicine X per day	Office use

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I, _____ hereby give my permission to camp officials to call a doctor or emergency medical service and for the doctor, hospital, or medical service to provide medical, to order injection, anesthesia or surgical care should an emergency arise. It is understood that camp officials will make a conscientious effort to locate the emergency contacts listed before any action will be taken. Whether or not emergency contact/contacts listed are contacted I accept the expense of emergency medical or surgical treatment. I hereby authorize Deaf Youth Camp and Baptist Hill Assembly and its employees and agents to dispense medications and attend to other special needs I may need. In the event I'm unable to consciously take my medication I give Deaf Youth Camp's nurse permission to administer all medicines listed as per directions on container or written out. I hereby authorize Deaf Youth Camp and Baptist Hill Assembly, and its employees and agents to attend to other special needs that I may require while attending the event. I understand the camp nurse and/or camp administrator will use the information provided below for emergency contact will be informed regarding my emergency situation and/or condition.

It is understood that Deaf Youth Camp will provide no medical insurance for such treatment, and that the cost thereof will be at my expense.

I have informed Deaf Youth Camp of any special medical needs and diagnosis and have provided them with complete and accurate instructions regarding those needs, including any necessary and lawfully prescribed drugs.

_____ _____

Signature *Date*

IN CASE OF AN EMERGENCY NOTIFY

NAME: _____ Relationship: _____

PHONE: (_____)_____ VP/Cell/Text (_____)_____

If Deaf Youth Camp, Baptist Hill or camp nurse is unable to contact person name listed above please put another person name to contact below:

NAME: _____ Relationship: _____

PHONE: (_____) _____ VP/Cell/Text (_____) _____

_____ _____

Signature *Date*

Other Medical Information: Answer Yes or NO

Medical Information	YES	NO
ADS/ADD/ADHD		
Seizures		
Bladder Problems		
Kidney Trouble		
Heart Trouble		
Emotional Difficulties		
Stomach Trouble		
Appendectomy		
Sleep Walking		
Earaches		
Gall Bladder Problems		

_____ _____

Signature *Date*

ADMINISTRATION OF OVER-THE-COUNTER MEDICATIONS

This information is for the nurse only. Need to know what over-the-counter medication you can take IF happen emergency you are unconscious/unresponsive. This is for your safety/protection.

If you've forgotten to bring your over-the-counter medications there are some available in the Nurse's Office during camp. In order for you to receive medication, please **authorize *each medication* by initialing the box next to the medication name below.** All over-the-counter medications will be administered according to the package dosage directions only unless otherwise documented in the box below.

You may choose to decline any medication be given to you from the camp nurse. If that is your wish, please clearly mark REFUSE MEDS across the box below.

Parent Initial	Name of Medication	Parent Initial	Name of Medication	Parent Initial	Name of Medication	
	Advil		Maalox		Excedrin Migraine	***Office Use***
	Tylenol		Gas X		Robitussin	
	Aleve		Mylanta		Halls Cough Drops	
	Ibuprofen		Tums		Chloraseptic Spray	
	Excedrin		Pepcid AC		Antibiotic Ointment	
	Bufferin		Rolaids		Caladryl Lotion	
	Motrin		Benadryl		Gaviscon	
	Imodium A-D		Sudafed		Emmetrol	
	Pepto-Bismol		Claritin/Loratidine		Midol	
	Zantac		Lotion with Lidocaine			

Food Allergy & Special Dietary Need

Name	Age	Male	Female

Email	VP Phone:	Cell/text:

Please check or list all allergies or special dietary needs. Please circle from 1 to 5 how severe is the allergy reaction to these foods (1 – uncomfortable 2 3 4 5 – Life Threatening)

- ☐ Gluten 1 – uncomfortable 2 3 4 5 – Life Threatening
- ☐ Nuts 1 – uncomfortable 2 3 4 5 – Life Threatening
- ☐ Dairy 1 – uncomfortable 2 3 4 5 – Life Threatening
- ☐ Eggs 1 – uncomfortable 2 3 4 5 – Life Threatening

Other:

_____

_____

_____

1. Do you have an epi-pen with you? YES NO
2. Did you bring your own food for your meals because of food allergies? YES NO
3. Did you write your name on your own food? YES NO
4. If you did not write your name on your food PLEASE write your name on your food.
5. If yes, please write down the name of your special food:

   _____

   _____

   _____