APPLICATION AND HEALTH RECORD

Silver State Baptist Youth Camp • P.O. Box 181 • Sedalia, Colorado 80135 • (303) 688-3420

Application and health record **MUST** *be filled out completely and signed by all campers, including adults.*

Church_____ Pastor_____ Date s Attending_____

Name _____ Age____ Boy ___ Girl___ Date of Birth_____

Address _____ Phone_____

City_____ State_____ Zip _____

Father's Name_____ cell_____ Mother's Name_____ cell_____

Address of Parent _____

In case of emergency, I hereby give my permission to the director of the Silver State Baptist Youth Camp to arrange for such medical, surgical or hospital care for my son, daughter or ward (child's name)_____ as may be necessary incidental to illness or injury occurring or notice of which arises while my son, daughter or ward is a camper at the Silver State Baptist Youth Camp. I further give permission for my son, daughter or ward to engaged in, supervised camp activities either on or off of the campground. I further hereby give permission to such physician or surgeon as the director may obtain, to carry out such medical, surgical or hospital procedures on my son, daughter or ward as in the opinion of such physician or surgeon may be indicted under the then existing circumstances. I understand that Silver State Baptist Youth Camp's insurance is **SECONDARY** accident insurance and it does **not** cover pre-existing conditions.

The above camper has permission to participate in all camp activities except as noted by me and/or the examining physician. I give permission to the physician selected by Silver State Baptist Youth Camp to order x-rays, routine tests, and treatment for the health of my child. If I cannot be reached in a medical emergency, I give permission to the physician selected by SSBYC to hospitalize, secure proper treatment for, and order injection, anesthesia, and/or surgery for my child. I also affirm that the information on this medical form is both complete and correct.

Medical Insurance Company_____ Policy No._____

Group #_____ Address of Ins. Co._____ Phone #_____

Family Doctor's Name_____ _____ Address_____ Phone_____

_____ X _____

Date ****Signature of Parent , Guardian or Adult Camper****

PERSON AUTHORIZED TO TAKE CHILD FROM CAMP:

Name:_____ Address_____

City_____ State_____ Phone Number_____

Person Unauthorized to Take Child From Camp: _____

Person to be contacted in case of emergency (other than parent)

Address _____ Phone_____

Father's and/or Mother's place of employment (No PO Box)

Name_____

Address _____ Phone_____

Name_____

Address _____ Phone_____

ACTIVITY RESTRICTIONS: I do not want my child to participate in the following activities:_____

_____

HEALTH RECORD: (Must be filled out or cannot attend SSBYC or attach copy of physical)

Physician's Name_____ Doctor Phone_____ Doctor Fax_____

Address_____ City_____ State_____ Zip_____

Date of Last physical examination within 24 months of camp_____

This child is planning to attend a residential camp away from his/her home and may be distant from medical care. (The camp has a nurse on duty at all times.) Your response to these questions will help in the care of the child.

Significant medical history (physical,serious injuries, illness or lacerations, learning, and/or psychological concerns)_____

_____

If camper is on medication, *Medication Form* MUST be completed and signed by PCP (MD, DO, PA or NP) and gaurdian.

Immunization Records: Attach certificate of immunization or complete the following:

Tetanus-Diphtheria(DT) _____ Diphtheria-Tetanus-Pertussis(DPT)_____ Polio _____

Hepatitis B_____ Measle-Mumps-Rubella(MMR)_____ Other _____

Drug Allergies: _____

Food Allergies: _____

I have examined this person and found him/her to be in satisfactory condition and capable of active participation in a regular camp program with exception:_____

****Signature of physician or nurse practitioner** (RN not acceptable) _____

Physician's Name_____ Phone_____ Date_____

Address_____ City_____ State_____ Zip_____

(PLEASE FILL OUT **BOTH** SIDES OF THIS APPLICATION)