

Camp Joy Retreat – Medical Information

Name of Camper _____ Address _____

City _____ State ____ Zip code _____ Phone # _____

Email _____

Please list any food, environment, or medication allergies:

Does the camper need any type of medication (including inhalers) while they are at camp? Yes__ No__

If “Yes”, please list any prescription or over-the-counter medications and the dosing specifications.

Medication #1: _____

Medication #2: _____

Medication #3: _____

Medication #4: _____

Medication #5: _____

Does the camper need to carry an inhaler with them? Yes__ No__ Not Applicable__

Is there any dietary restrictions we should be aware of? Yes__ No__

If “Yes”, please provide restriction details:

Name of attending Medical Physician: _____

Physician’s Phone: (123-456-7890 ext.210) _____

Parental Medical Release:

By entering my name and the date below, I am agreeing to the following statement and method of transportation....

“I give permission for my child/teen to attend the camp Joy retreat for which I am registering. It is understood that if medications are required, they will remain in the possession of the Camp Director or other designated staff member. It is further understood that my child will be “Self-administering” any medication(S) in the presence of an adult, according to the dosing specifications. In the event that a parent/guardian cannot be reached in an emergency, I hereby give permission to the physician selected by camp to hospitalize, secure proper treatment for, and order injection(s), anesthesia, and surgery for him/her.”

Parent/Guardian Name (Print) _____

Parent/Guardian Signature: _____

Today’s Date _____