



EVENT: _____

Office Use Only	
Meds	
Holds	

MEDICAL FORM

This form is required for all attendees.

Church City: _____ Church Name: _____

Attendee First Name: _____ Middle Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Gender (Select One): _____ Date of Birth (mm/dd/yyyy): _____ Age: _____ If student, 2021-2022 Grade: _____

Emergency Contact Information:

Primary Contact: _____ Relationship: _____

Cell Phone: _____ Additional Contact Number: _____

Second Contact: _____ Relationship: _____

Cell Phone: _____ Additional Contact Number: _____

Medical Information:

Medical Insurance Provider: _____

Policy Number: _____ Group Number: _____

Physician's Name: _____ Phone: _____

List all allergies/medical conditions and any special considerations of which we should be aware:

May the attendee listed above be given over-the-counter, non-prescription medications or applications, not to exceed recommended dosage for stomach discomfort, burns, cuts, insect bites, rash, scrapes, or other minor ailments? (Select One)

Yes No

PLEASE READ AND INITIAL BESIDE EACH STATEMENT:

___ ALL MEDICATION MUST BE IN THEIR ORIGINAL CONTAINERS WITH A CURRENT/CORRECT LABEL.

___ Pills sent in plastic baggies or weekly dose containers will not be given.

___ Expired medication will not be given.

___ All inhalers, nasal sprays, and epi-pens must be in the original box with the prescription label.
(If the box is not available, ask the pharmacy to print a label.)

___ All medication, vitamins, supplements, and oils must be stored in the First Aid Station.

___ All medication, vitamins, supplements, and oils must be administered by the First Aid Staff in the First Aid Station.

___ **NO MEDICATION, VITAMINS, SUPPLEMENTS, OR OILS WILL BE ADMINISTERED TO MINORS UNLESS LISTED ON THIS SIGNED FORM.**

___ If the parent/guardian lists a dosage for medication that is **different** from the doctor's prescribed dosage listed on the bottle, the listed dosage will be administered, and the parent/guardian will assume all responsibility for the changes.

WILL THIS CAMPER/COACH BE BRINGING MEDICATION, VITAMINS, SUPPLEMENTS, AND/OR OILS TO CAMP?

Name of Medication	Dosage	Time to be Given	How Taken

DO YOU HAVE ANY COMMENTS FOR FIRST AID STAFF?

MEDICAL RELEASE STATEMENT AND EVENT POLICIES & PROCEDURES AGREEMENT

FOR ATTENDEES UNDER THE AGE OF 18:

I, the parent/legal guardian of _____ (attende), authorize the event first aid personnel to administer the medications listed above. I hereby authorize event personnel to obtain medical care or dental care, if necessary. My signature authorizes emergency treatment in the event of illness/injury when I am not immediately available. I understand, if necessary, the attendee will be taken to a nearby medical facility and will be attended by a physician on call. I further understand that I will be responsible for any medical expenses incurred, and that my medical insurance will be the primary insurance with Oklahoma District Council's insurance being secondary. I also hereby authorize this document to be released to first responders and emergency personnel. I understand that any person with a fever, rash, pink eye, head lice, or other signs of illness will be sent home. I further understand that the parent/legal guardian will be responsible for their child's transportation in the event of an illness or injury. I also agree with and support the enforcement of the event's Policies and Procedures.

Signature of Parent/Legal Guardian _____ Date _____

FOR ATTENDEES OVER THE AGE OF 18:

I, _____ (attende), authorize the event first aid personnel to administer the medications listed above. I hereby authorize event personnel to obtain medical care or dental care, if necessary. My signature authorizes emergency treatment in the event of illness/injury if I am unconscious or unable to consent to treatment. I understand, if necessary, I will be taken to a nearby medical facility and will be attended by a physician on call. I further understand that I will be responsible for any medical expenses incurred, and that my medical insurance will be the primary insurance with Oklahoma District Council's insurance being secondary. I also hereby authorize this document to be released to first responders and emergency personnel. I understand that any person with a fever, rash, pink eye, head lice, or other signs of illness will be sent home. I further understand that I am responsible for my own transportation in the event of an illness or injury. I also agree with and support the enforcement of the event's Policies and Procedures.

Signature of Attendee _____ Date _____