Elevate! PERSONAL/HEALTH INFORMATION

Complete and bring this form to camp with you.
THIS IS VERY IMPORTANT!!
This certificate is essential to the camper's registration and participation in all recreational activities, including swimming.

Name of Participant:_____ Date of Birth:_____/_____/_____
Last First Middle

Address:_____
Street ! City State Zip

Grade Completed _____(2015) Home Phone: (___)_____ E-Mail Address _____

Father's Employment _____ Phone: (_____)_____

Mother's Employment _____ Phone: (_____)_____

Church _____ City _____

HEALTH HISTORY: (ANSWER YES OR NO AND GIVE DATES WHICH APPLY)

If you need to give an explanation, please use a separate piece of paper and attach to this form.

	Yes No		**Yes No**		**Yes No**
Athlete's Foot	☐ ☐	Bed-Wetting	☐ ☐	Heart Trouble	☐ ☐
Asthma	☐ ☐	Sleep Walking	☐ ☐	Menstrual Problems	☐ ☐
Convulsions	☐ ☐	Chicken Pox	☐ ☐	ADD	☐ ☐
Diabetes	☐ ☐	Nose Bleed	☐ ☐	Sinusitis	☐ ☐
Epilepsy	☐ ☐	Polio	☐ ☐	Rheumatic Fever	☐ ☐
Fainting	☐ ☐	Bronchitis	☐ ☐	Kidney Trouble	☐ ☐
Frequent Colds	☐ ☐	Abscessed Ears	☐ ☐	Tuberculosis	☐ ☐
Sore Throat	☐ ☐	Mumps	☐ ☐	Depression	☐ ☐
Whooping Cough	☐ ☐	Measles	☐ ☐	Has had appendix out	☐ ☐
Surgeries: list--					☐ ☐

Allergic Reactions:
If yes, list any special instructions on separate sheet

Insect Bites	☐ ☐	Penicillin	☐ ☐	Other Drugs	☐ ☐
Serious Ivy	☐ ☐	Oak	☐ ☐	Sumac Poisoning	☐ ☐
Foods	☐ ☐				

Has camper ever had head lice Yes ☐ No ☐ **Camper is now free from nits and/or lice** Yes ☐ No ☐
Note: Please check camper before sending to camp for the above. Camper is subject to be checked by the camp nurse before being allowed to check-in.

Immunizations

Vaccine	DOE Code	Dose 1 Mo/Day/Yr	Dose 2 Mo/Day/Yr	Dose 3 Mo/Day/Yr	Dose 4 Mo/Day/Yr	Dose 5 Mo/Day/Yr	
DTaP/DTP	A						
DT3	B						
Td4	C						
Polio5	D						
HIB6	E						
MMR (combined)7	F						
(Separate)8	G,H,I						
Hepatitis B9	J						
Varicella 10	K						
Varicella Disease	L						
Last Tetnus Shot							
Tetnus Booster							

MEDICATION: Is participant currently taking regular medication? Yes ☐ No ☐ For what reason?

_____

Any restriction on participant? If so, give details. _____

_____

In case of emergency notify _____ Phone: (_____) _____
Another way you may be reached _____

IMPORTANT: Do not send applicant to camp - (1) if he/she has been exposed to any contagious or infectious disease during the two weeks prior to camp, or (2) if participant has ring worm, rash, open sores at camp time.

IN CASE OF MEDICAL EMERGENCY, I will assume obligation for the necessary expense not covered by the camp insurance policy on the participant. I hereby give permission to the physician(s) selected by the camp director, to hospitalize, secure proper treatment and to order injections, anesthesia or surgery for my child. I understand that my insurance will serve as the primary insurance should a claim be filed on behalf of my child.

Parental signature _____

My insurance company is: _____

Policy Number: _____

(Attach A Copy Of Insurance Card (Front And Back) Should Be Attached To This Form)

PARENT'S SIGNATURE _____ Date: _____/_____/_____

MEDICAL RELEASE

(Must Be Notarized)

A representative of the **Elevate** Worship Camp, or The Baptist College of Florida, has my permission to seek medical help for my child,

_____, should he/she need it.

Date: _____/_____/_____ _____

Signature of Parent/Guardian

_____ Witness _____ (not a relative

Notary Public
State of Florida

_____

My Commission Expires