CAMPER INFORMATION:

Name:

Date of Birth:

☐ Male ☐ Female

Grade the student will be entering this fall:

Parent Name

Address:

City, State, Zip

Phone Number

Email:

Church Name:

Check the following over-the-counter medication that may be given to your camper by the camp nurse while at camp: (if left unchecked, option will be considered "no")

☐ Acetaminophen (Tylenol) ☐ Calcium Carbonate (Tums)
☐ Diphenhydramine (Benadryl) ☐ Ibuprofen (Advil/Motrin)
☐ Anti-Itch Ointment

MEDICAL INFORMATION **(THIS SECTION IS REQUIRED TO BE ANSWERED)**

Emergency Contact, phone number and relationship to camper:

A

Check One: ☐ YES ☐ NO (If Yes, please list)

Are you up to date on all Immunizations? ☐ YES ☐ NO

Date of last Tetanus:

Does the camper have allergies? ☐ YES ☐ NO (If Yes, please list)

Will the camper be bringing any routine or as-needed prescription or over the counter medication, vitamins/supplements, or essential oils to camp? ☐ YES ☐ NO
Please list all medications on the Authorization for Administration of Medication form on the back of this registration
All Medications and Prescriptions MUST be in the original container. (Not in bags or daily dispensers)

CONSENT FORM & AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I will not hold or attempt to hold Camp Liberty liable for any loss, damage, or injury to person or property caused by an act or neglect of other persons, caused in any manner other than the willful or negligent act of Camp Liberty, its agents and employees, and will indemnify and hold Camp Liberty harmless from any liability for damages or claims against Camp Liberty arising out of or in any way related to any such loss, damage, or injury. I release Camp Liberty, including its trustees, employees and agents, from me or my child's physical injury, including death, or illness while at the activity. I/We will assume the risk associated therewith, whether known or unknown to me/us at this time. This release is also intended to include all claims of my family, estate, heirs, personal representatives or assigns. I/We hereby give permission to the medical personnel selected by Camp Liberty to secure administer treatment and to maintain and/or release any medical records necessary for insurance purposes. Camp Liberty does not provide secondary insurance. I understand that I will be expected to pay any medical expenses through my medical insurance company and guarantee payment for services not paid by insurance. I understand that I must sign this form in order for my camper to attend Camp Liberty. I further understand that Camp Liberty does not provide medical Insurance coverage for the participant, and any medical expenses incurred will be paid by me or my insurance. I hereby grant permission for the Participant to attend camp, participate in all the camp activities and to be treated by a licensed healthcare professional in the event of any injury , accident, illness, or any other situation that may require medical attention.

Parent/Guardian signature ______________________________ Date ____________________

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION FORM

NAME ____ DATE OF BIRTH _________________

Parent Signature: _____________________________________

Guidelines:

1. Medications must be in original container with doctor's directions if it is a prescription (no pills ion bags or daily dispensers).
2. Please send an inhaler if your child has asthma. Please send an Epi-pen if your child has a history of severe allergic reaction.
3. Primary dispensing times for medications will be at meal times unless otherwise directed by a physician

Medications
Name:
Dose:
Frequency:
Reason:

Medications
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