the Shepherd's Staff inc.
Christian Conference & Retreat Center

Medical Form

*Please take the time to carefully and neatly complete all sections of this form. We must have a medical form on the file for **every** camper by the first day of camp. Please complete **both** pages.*

Name ________________________ Birthdate ____ / ____ / ______ Male _____ Female ____

Grade Entering ____________ Height ________ Weight ________ Eye Color __________

Wears Glasses (Yes _____ No _____) Wears Contacts (Yes _____ No _____)

Mailing Address ____

City ____________________ State ______ Zip ____________

Parent/Guardian Name(s) ________________________ Email ____________________

Best Way to Contact: Home (____) ____________ Work (____) ____________ Cell (____) ____________

Emergency Contact Information

In the Event of an emergency we will try to contact the parent/guardian listed above. If the parent or guardian cannot be contacted, list below (in order of priority) who we should contact.

These contacts should be individuals other than the parent or guardian listed above.

Contact #1	Contact #2	Contact #3
Name ______________	Name ______________	Name ______________
Home Phone (___) __________	Home Phone (___) __________	Home Phone (___) __________
Work Phone (___) __________	Work Phone (___) __________	Work Phone (___) __________
Cell Phone (___) __________	Cell Phone (___) __________	Cell Phone (___) __________
Relationship ____________	Relationship ____________	Relationship ____________

IMPORTANT INFORMATION!

Prescription medications MUST arrive in original container(s). All medication will be administered in the prescribed dosage only. ***Any medications outside of original container will not be administered.***

Shepherd's Staff is not financially responsible to pay for campers' medications prescribed while at Shepherd's Staff. Parents or guardians will be notified and will be responsible to make immedate payment with the pharmacy.

Medical/Health Insurance Information

Shepherd's Staff supplemental medical insurance pays only medical expenses caused by an accident up to $10,000 within one year of accident, that is not covered by your family health plan. This means that medical expenses caused by doctor's visits for such things as flu, colds or appendicitis are the responsibility of the participant and/or their family, and are not covered by Shepherd's Staff.

Do you have health insurance? Yes ___ No ___ Please include photocopy of insurance card.

Health insurance provider ____________________ Policy Number ________________

Family Doctor ________________________ Phone (_____) ________________

Clinic Name ____

City ________________________ State ____________ Zip ____________

**** A photocopy of your insurance card MUST accompany this Medical Form. ****

Medical History

Medication Allergies ______________________________

Food Allergies ______________________________

Environmental Allergies ______________________________

___ No Known Allergies   Vaccinations recieved for 2012 ___ H1N1   ___ Influenza

Please check on the list below all conditions that the participant has a tendency towards:

___ asthma	___ convulsions	___ nervousness	___ stomach problems
___ diabetes	___ physical handicap	___ hyperactivity	___ Other (please list)
___ epilepsy	___ bed wetting	___ hay fever	______________
___ seizure disorder	___ earaches	___ homesickness	______________
___ heart condition	___ insomnia	___ sleepwalking	______________

List any recent illnesses, accidents or surgery, as well as the dates and current status of the illness, accident or surgery:

____

____

Does the participant take any medications on a daily basis? Yes ___ No ___

Has his/her medication changed in the last 14-30 days? Yes ___ No ___

Has his/her dosage changed in the last 14-30 days? Yes ___ No ___

Will the participant need any medications while he/she is at camp? Yes ___ No ___

History of anaphalactic shock Yes ___ No ___

If you checked yes, please list all the medications and time of day they need to be taken. Please note that all prescription medications must arrive at Shepherd's Staff in their original containers, and will be administered per the doctor's prescription.

Medication	Dose	Directions (ex: 2xday, etc.)	Time(s)

In addition to prescribed medications, please check all of the following over-the-counter medications that the participant is authorized to receive while at camp. Please not that only medications that have been authorized will be administered while the participant is at camp.

___ Acetominophen   ___ Ibuprofen   ___ Stomach Antacid   ___ Decongestant   ___ Antihistamine

___ Other OTC medications ______________________________

Dietary Restrictons

____

____

Activity Restrictions

Please indicate any restrictions for your child.

___ Swimming restrictions ______________________________

___ Activity Restrictions ______________________________

Parental Consent

I certify that the above information is accurate. In the event of an emergency, I hereby give permission for the participant to receive medical treatment at the nearest hospital or clinic. I expect to be contacted as soon as possible, should this happen. If I choose not to provide Shepherd's Staff with the necessary information, such as serious medical conditions or allergies, I will not hold Shepherd's Staff and/or camp personnel liable for any injury or death that could occur to the participant as a result of the lack of this information.

______________________________   ______________________________

Participant's Signature   Date   Parent/Guardian Signature (if under 19)   Date

Please return this form to Shepherd's Staff:

PO Box 70, Rexford KS 67753 Questions: jdingw@yahoo.com

office@shepherdstaff.org * 888.687.2565 * www.shepherdstaff.org