

**CMMBC CAMPER MEDICAL FORM**  
2390 Horse Hollow Rd., Jonesville, VA 24263  
276-346-1013 [www.cmmbc.org](http://www.cmmbc.org)

Camper Name: \_\_\_\_\_ Gender: M / F Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Select the camp(s) to be attended:

- Pathfinders (grades K-5)  Trailblazers (grades 4-6)  Junior Camp (grades 6-8)  Senior Camp (grades 9-12)

**Parent/Guardian Information**

Name 1: \_\_\_\_\_ Phone #1: (\_\_\_\_)\_\_\_\_\_ Phone #2: (\_\_\_\_)\_\_\_\_\_

Name 2: \_\_\_\_\_ Phone #1: (\_\_\_\_)\_\_\_\_\_ Phone #2: (\_\_\_\_)\_\_\_\_\_

Address: if different from camper registration \_\_\_\_\_

**Emergency Contact (other than parent)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone #1: (\_\_\_\_)\_\_\_\_\_ Phone #2: (\_\_\_\_)\_\_\_\_\_

**Health Insurance/Doctor Information**

Insurance Company: \_\_\_\_\_ Policy /Group # \_\_\_\_\_

Child's Doctor's Name: \_\_\_\_\_ Doctor's Phone: (\_\_\_\_)\_\_\_\_\_

**Health History**

If the answer to any of these questions is "yes," please check the box in front of condition and provide additional information as appropriate below.

- diabetes seizures allergies allergy shots (desensitization) glasses contact lenses

List food allergies or sensitivities: \_\_\_\_\_

\_\_\_\_\_

Other significant information? \_\_\_\_\_

\_\_\_\_\_

Last Tetanus Booster: \_\_\_\_\_ (year)

**For Overnight Camps:** Does the camper have a history of sleep disturbance (bedwetting, sleep walking, nightmares) on regular basis? yes no

If yes, please explain \_\_\_\_\_

\_\_\_\_\_

**For Females:** Has she menstruated? yes no If no, does she know about it? yes no

## Medication Information

Does camper usually take any medication that is being discontinued for summer/camp week? yes or no

If yes, please explain: \_\_\_\_\_

**Please check the boxes for any over-the-counter medicines that can be dispensed to this camper, as deemed necessary by the camp nurse:**

<i>For Fever/Pain</i>	<i>For Cold/Allergies</i>	<i>For Stomach</i>	<i>For Topical Treatment</i>
<input type="checkbox"/> Acetaminophen (Tylenol) <input type="checkbox"/> Ibuprofen (Advil)	<input type="checkbox"/> Diphenhydramine (Benedryl) <input type="checkbox"/> Pseudoephedrine Hydrochloride (Sudafed) <input type="checkbox"/> Loratadine (Claritin) <input type="checkbox"/> Fexofenadine (Allegra)	<input type="checkbox"/> Calcium Antacid Tablets (i.e. Tums) <input type="checkbox"/> Bismuth subsalicylate (Pepto Bismol) <input type="checkbox"/> Loperamide (Immodium)	<input type="checkbox"/> Antibiotic Ointment <input type="checkbox"/> Burn Ointment <input type="checkbox"/> Calamine Lotion <input type="checkbox"/> Hydrocortisone cream <input type="checkbox"/> Sting Eze for insect bites <input type="checkbox"/> Chloraseptic spray <input type="checkbox"/> Cough drops

**Please note the camper's current medications (prescription, over-the counter, and vitamins/supplements) that will be given to camp nurse during camper registration. All medications must be in original containers.**

Name of medication	dosage	schedule	comments

## Parent/Legal Guardian Authorization - SIGNATURE REQUIRED

My signature below indicates that the above named camper has permission to engage in all camp activities (unless noted otherwise) on and off camp grounds, and to be transported to and participate in, excursions off camp grounds (including swimming), under the supervision of CMMBC staff. I understand that campers are expected to comply with camp rules, and any camper disregarding camp rules is subject to being sent home with no refund of camp fees.

I give permission for the CMMBC staff to:

- (1) provide routine health care (including medication) for the above named camper. I understand all medications, including over-the-counter, must be kept by the nurse. If deemed necessary, I authorize them to obtain services of medical professionals and to provide necessary related transportation. I authorize any physician and any hospital, through its medical staff, to take appropriate measures. I understand that I am responsible to pay for my child's medical care, including any emergency care authorized in this section. I agree to the release of these records for insurance purposes and/or as requested by a physician for the care of my minor child. The camp will make reasonable efforts to notify parents promptly if measures other than routine care are taken.
- (2) photograph and record this child and to use his/her images and sound prints in promotional materials for CMMBC.
- (3) use of a photocopy of this form as my authorization

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

## Camper Agreement - SIGNATURE REQUIRED

I understand the importance of, and will adhere to, camp safety regulations and the directions given to me by camp leaders so they can provide me and all campers with a safe, pleasant and memorable camp experience. I will be sure to give all medications to the nurse. I understand that if I fail to follow camp rules, I may be sent home.

Signature of camper \_\_\_\_\_ Date \_\_\_\_\_