CAMP EDEN CAMPER
REGISTRATION/MEDICAL RELEASE FORM

CAMPER'S NAME________________________ BIRTHDATE______________ SEX____

ADDRESS________________________ PHONE______________

CITY______________ STATE______________ ZIPCODE______________

CAMP CHILD ATTENDING______________ SENDING CHURCH______________ DATES_____ to _____

PARENT/GUARDIAN

Name________________________ Relationship______________

Address________________________ Phone______________

Place of Employment________________________ Phone______________

Address of Employment________________________

Name________________________ Relationship______________

Address________________________ Phone______________

Place of Employment________________________ Phone______________

Address of Employment________________________

Relative, Neighbor, or Friend to be contacted in case of emergency, if neither Parent/Guardian can be reached:

Name______________ Relationship______________ Phone______________

Address________________________

Other Adults permitted to take child from camp if different from Parent/Guardian:

Name______________ Relationship______________ Phone______________

Address________________________

Person(s) NOT permitted to take child from Camp: ________________________

HEALTH INSURANCE NUMBER(S) AND ANY SPECIAL INSTRUCTIONS CONCERNING YOUR HEALTH INSURANCE that we should be aware of:

____

____

CAMPER'S DOCTOR: Please print clearly or use doctors stamp (This must be filled out)

Name______________ Address______________ Phone______________

I understand that if my child requires emergency medical attention, the Camp Eden staff will attempt to contact me first. Should I be unavailable, I hereby authorize any emergency medical treatment that is deemed necessary. I also give permission for camp personnel to transport my child or arrange transportation, in an emergency or if medical care is needed.

________________________ Date______________

REQUIRED SIGNATURE OF PARENT/GUARDIAN

I hereby give permission for my child to go on trips away from camp premises, whether on foot or by vehicle. I give permission for my child to participate in all camp activities with the following exceptions: ______________

________________________ Date______________

REQUIRED SIGNATURE OF PARENT/GUARDIAN

HEALTH HISTORY -- May be completed by parent/guardian

Please list any medical condition/concern, recent injury or hospitalization:

____

Known allergies (check if applicable): Hayfever ________ Bee sting ________ Food ________ Drug ________

Explain: ______________________________

Describe any special diets which the camper must follow:

____

Are there any special cabin requirements or requests? (i.e. to be with someone, bottom bunk only, bed pad, etc.)

____

MEDICATIONS: The following medications, available at Camp Eden, may be administered by Camp Eden personnel in order to relieve minor pain and discomfort. MARK AN "X" AFTER YES OR NO:

Ibuprofen (Advil)	Yes____	No____	Sucret Lozenge	Yes____	____	Imodium AD	Yes____	No____
ChlorTrimeton	Yes____	No____	Tylenol	Yes____	No____	Mylanta	Yes____	No____
Benadryl	Yes____	No____	Neosporin	Yes____	No____	LanocaneYes	Yes____	No____
Benadryl spray	Yes____	No____	Sun screen	Yes____	No____	Sudafed	Yes____	No____
Hydrogen Peroxide	Yes____	No____	Vicks	Yes____	No____	Cough Drops	Yes____	No____
calamine Lotion	Yes____	No____	Pepto-Bismal	Yes____	No____	Rubbing Alcohol	Yes____	No____
Chloraseptic spray	Yes____	No____	Alka Seltzer	Yes____	No____	Maalox Plus	Yes____	No____
Dermoplast Spray	Yes____	No____	Hydrocortizone 1%	Yes____	No____			

List ALL prescription and non prescription medications which the camper will bring to camp. These must be turned in to the nurse at Check-in. All medications will be administered by the Camp Eden medical person. ALL PRESCRIPTION MEDICATIONS MUST BE IN THE ORIGINAL PHARMACY LABELED CONTAINERS.

Name of Medication	Dosage	Frequency	Reason for Medication
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DOCTOR'S STATEMENT --Must be completed by licensed physician or nurse practitioner.

Immunization Record Please list date of last immunization.

________ Tetanus ________ Diphtheria ________ Polio

________ Smallpox ________ whooping Cough ________ Measles

I have examined this camper within the past 24 months and have found him/her to be in satisfactory condition, free from any contagious disease, and capable of active participation in a regular camp program except as follows:

____

Signature of Doctor ______________________________

Address ______________________ ***Phone*** ____________

You must have a doctor's or licensed nurse practitioner signature in order to come to camp.

Without a signature, your child cannot come to camp.