Lakeview Ministries ◊ 13500 W. Lake Rd. ◊ Seymour, IN 47274 ◊ (812) 342-4815

Emergency Medical Information Form for Family Programs

This form must be completed and submitted to the Camp Lakeview office prior to final admission of the camper into the camp program. Failure to properly complete and submit this form will result in the non-acceptance of the family into the camp program. This form may be mailed or given to the office personnel at the time of registration. If the form is mailed, make certain that enough time is allowed for postal service to deliver the form prior to the day of registration. Camp Lakeview shall not be held primarily responsible for medical expenses incurred by the camper through accident or illness before, during or after enrollment in the camp program. Therefore, it is extremely important that complete insurance information be provided by the guardian.

Family Information:

Camper Name: FIRST ________ MIDDLE ________ LAST ________

Birthdate: ___/___/___ Sex: ________ Age: ________

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Birthdate: ___/___/___ Sex: ________ Age: ________

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Birthdate: ___/___/___ Sex: ________ Age: ________

Camper Name: FIRST ________ MIDDLE ________ LAST ________

Birthdate: ___/___/___ Sex: ________ Age: ________

Family Address:

Family Home Address: STREET ADDRESS ________ CITY ________ STATE ____ ZIP ________

Family County of Residence: ________ Home Phone: (____) ________

Authorization for Emergency Medical/Dental Care

I, the undersigned parent, spouse, and/or natural guardian of all individuals listed above do hereby authorize the Camp Lakeview Health Services Staff (and/or any other qualified adult appointed or designated by them) (1) to provide routine health care and administer prescription medications, (2) to consent to medical, surgical and dental care for such individual(s); (3) to consent to any diagnostic test, medical, surgical or dental procedure or treatment as may be considered therapeutically necessary by the physician, surgeon, dentist or other health care personnel providing care for such individual(s); (4) to employ physicians, surgeons, dentists, nurses and other health care personnel as may be deemed necessary for such individual(s); (5) to admit such individual(s)to any hospital, clinic, emergency room, laboratory or other health care or diagnostic facility for examination, treatment, surgery or care; and (6) to sign all necessary consents and authorizations.

It is understood that this authorization is given in advance occurrence of any condition or situation which would necessitate any such medical, surgical or dental care being required; but is given to provide authority to obtain such care if it should be required. I fully understand the consequences of the foregoing statements and sign this AUTHORIZATION TO CONSENT TO MEDICAL AND DENTAL CARE knowingly, freely and willingly.

Signature: ________________ Date: ________

Printed Name: ________________

Emergency Contact Information:

Not someone who will be at camp:

Name: ________________ Relationship to Family: ________

Home Address: STREET ADDRESS ________ CITY ________ STATE ____ ZIP ________

Home Phone: (____) ________ Cell Phone: (____) ________ Work Phone: (____) ________

Medical Insurance Information:

Attach a copy of medical insurance card to this form.

Insurance Company: ________________ Insurance Company Phone: (____) ________

Policy Number: ________________ Group Number: ________

Subscriber Name: ________ Social Security Number: ________ Birthdate: ___/___/___

PLEASE STAPLE A COPY OF YOUR MEDICAL INSURANCE CARD HERE!

Family Name: ________________

Date of Program: ________________

Camp Lakeview Program Name: ________________

Health History:

Primary Physician Name:_______________________________ Phone Number:_________________________

Is any family member allergic to:

Bee Stings	☐ Yes	☐ No	Food (gluten, nuts, etc.)	☐ Yes	☐ No	Dairy	☐ Yes	☐ No
Poison Ivy / Oak	☐ Yes	☐ No	Penicillin	☐ Yes	☐ No	Other	☐ Yes	☐ No

Is any family member subject to:

Frequent colds	☐ Yes	☐ No	Frequent sore throats	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Constipation	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No	Bed Wetting	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No	Ear Trouble	☐ Yes	☐ No	Sleep Walking	☐ Yes	☐ No
Fainting	☐ Yes	☐ No	Upset Stomach	☐ Yes	☐ No	Other	☐ Yes	☐ No

Has any family member had:

Abscessed Ears	☐ Yes	☐ No	Chicken Pox	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Athletes Foot	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Hernia (Rupture)	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Heart Trouble	☐ Yes	☐ No
Asthma or Hay Fever	☐ Yes	☐ No	ADD/ADHD	☐ Yes	☐ No	Eating Disorder	☐ Yes	☐ No

If you answered yes to any of the above questions, please explain in the space below, including the name of the family member to which it pertains (an additional sheet may be attached for more room):

Has any family member had any operations or serious injuries? ☐ Yes ☐ No
If yes, please comment:

Are there any restrictions of activity for medical reasons? ☐ Yes ☐ No
If yes, please comment:

Are there any additional details or information on the camper's health that either the camp staff or an attending doctor should know?

Immunization Record:

Please list each family member's first name and the date of their last tetanus booster. In the space marked "other", please list all common immunizations which the family member has not had.

Name:____________________ Tetanus Booster:____/____/____ Other:______________________________

Name:____________________ Tetanus Booster:____/____/____ Other:______________________________

Name:____________________ Tetanus Booster:____/____/____ Other:______________________________

Name:____________________ Tetanus Booster:____/____/____ Other:______________________________

Name:____________________ Tetanus Booster:____/____/____ Other:______________________________

Name:____________________ Tetanus Booster:____/____/____ Other:______________________________

Prescribed Medications:

Please list all medications brought to camp:

Family Member	Name of Medication	Dosage	Times Given	Reason for Medication	Prescribing Physician