



ICE CAMP MEDICAL FORM

REQUIRED FOR EVERY CAMPER IN YOUR GROUP

Camper's Name (Please print): _____ Male Female

Camper's Date of Birth: _____ Age: _____ Camper Email: _____

Address: _____

City _____ State _____ Zip _____

Parent/Guardian Names: _____

Parent/Guardian Cell #'s: _____

Alt Phone #'s: _____

Parent/Guardian Emails: _____

HEALTH HISTORY

Major Hospitalizations, Surgeries, Injuries (Include year)

Allergies (Plant, Food, Insect, Medication, etc.)
(List allergy and treatment)

SPECIAL CONDITIONS (Please check all that apply)

- Shortness of breath Frequent earaches, sore throats
- Excema, skin rashes Trouble passing urine
- Convulsions, seizures Speech problems
- Heart trouble Hayfever, asthma, wheezing
- Menstrual problems Diabetes
- History of bleeding Bedwetting
- Sleepwalking Other _____

Usual treatment for condition(s) above:

MEDICATIONS

(List all medications the child is bringing to camp)

Medication	Dose	Frequency	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

IMMUNIZATION DATES

MMR _____ DP Tetanus Booster _____
Hepatitis B _____ Other _____

DATE OF LAST PHYSICAL _____
NAME OF PHYSICIAN _____
PHYSICIAN'S PHONE # _____

PERSON OTHER THAN GUARDIAN TO BE NOTIFIED IN EMERGENCY SITUATION _____
PHONE NUMBER: _____ ALT PHONE (Cell or Work): _____

INSURANCE INFORMATION

Attach clear copies of both sides of your health insurance card OR fill in completely the information below.

Insurance Company Name: _____ Policy Number _____
Group/Employer Name: _____ Group Number _____
Additional Information: _____

I certify that the above medical information is, as of this date, accurate and correct to the best of my knowledge. I certify that photographs and videotape pictures of my child participating in camp activities may be used in promotional materials for the camp. I give my permission for Miracle Camp and Retreat Center to send me emails and to my camper regarding upcoming events and news (we will not sell your information).

I hereby grant permission to the medical personnel selected by the camp director to order x-rays, routine tests, and treatment for my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above. I also grant permission for medical personnel to obtain access to necessary medical, psychiatric or social work records. This form may be photocopied for use out of camp.

Parent\Guardian Signature: _____ Date: _____