

Health Record

Camper's Physician _____

City _____

Phone _____

I attest that the camper for whom this application is made is in good physical condition and is able to participate in all camp activities.

Exception: _____

Asthma

Diabetes

Date of last tetanus booster: _____ Allergic to bee stings Yes No Other allergies: _____

If camper has a history of drug allergies, please list _____

Current Medications: _____

List any non-prescription drug restrictions: _____

Is Camper free of communicable diseases? Yes No If no, explain: Attach additional page if needed.

Has Camper had serious injury or surgery? Yes No If yes, explain: Attach additional page if needed.

PERMISSION TO SEEK MEDICAL CARE

I do hereby state that I am the parent or legal guardian of _____, a minor. I authorize Christian Contender Ministries near the city of Freedom, County of Owen, State of Indiana to consent on my behalf for any necessary emergency medical care, examination, anesthetic, medical diagnosis, surgery or treatment, and/or hospital care to be rendered to the above named minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine in the United States of America. This application is made with my approval. I agree to the above statements and will in no way hold the camp management responsible for any accident/sickness that might befall the applicant caused by negligence or disobedience on the part of the camper(s).

X

Printed Name of Parent or Legal Guardian

Signature of Parent or Legal Guardian

Date

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Is Camper free of communicable diseases? Yes No If no, explain: Attach additional page if needed.

Has Camper had serious injury or surgery? Yes No If yes, explain: Attach additional page if needed.

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