HOLLOW ROCK YOUTH

MEDICAL PERMISSION FORM

PARENT PERMISSION: I hereby grant permission for my child to fully participate in all activities of Hollow Rock Campmeeting. While I understand that Hollow Rock Campmeeting will take all reasonable steps to provide care and safety for my teen. I hereby release and hold harmless from liability Hollow Rock Campmeeting, its board members, staff members, volunteer members, and/or agents in the event of injury to my teen not resulting from the negligence of any such, volunteers and/or agents while my teen is engaging in any camp activity. In permitting my teen to participate, I agree that such responsibility will remain with me, as parent or guardian of my teen.

EMERGENCY AUTHORIZATION: I hereby give permission to the medical personnel attending to the treatment of my child to order x-rays, routine tests and treatment. In the event I cannot be reached in an emergency, I hereby give permission to the attending physician to hospitalize, secure treatment for, and to order injection and/or anesthesia and/or surgery for my teen named on this form. This form may be copied.

Signature of parent/guardian_____ Date_____

Witness_____ Date_____

EMERGENCY ADMISSION INFORMATION

Parent/Guardian - These are questions that will be asked of your teen in the event that there is a need to take him/her to the emergancy room of the hospital. Having this information will expedite the admission process and the treatment of the injuries or illness.

ATTENDEES INFORMATION

Last Name_____First Name_____MI_____Sex_____

Home Address_____

City_____State_____ Zip_____

Home Phone_____Parent's Work Phone_____

Emergency Phone_____Relationship_____

County of Residence_____Birthdate_____Age_____SSN#_____

INSURANCE COMPANY INFORMATION

Complete Name of Insurance Company_____

Policy Holder Name_____

Group #_____Group Name_____

Address of Insurnace Company_____

City_____State_____Zip_____

Where is the policyholder employed?_____

Employer's Address_____

City_____State_____Zip_____

Employer's Phone Number_____If self-employed, give occupation_____

HEALTH HISTORY FORM

Health History (Mark an "X" and give approximate dates)

	DISEASES	ALLERGIES
❑ Ear, Nose, Throat disorder_____		
❑ Heart Defect/disease _____	❑ Mononucleosis _____	❑ Ivy poisoning, etc. _____
❑ Convulsions _____	❑ Chicken Pox _____	❑ Insect stings _____
❑ Diabetes _____	❑ Measles _____	❑ Penicillin _____
❑ Bleeding, clotting disorders_____	❑ German Measles _____	❑ Other drugs _____
❑ Hypertension _____	❑ Mumps _____	❑ Foods _____
❑ Asthma _____	❑ Hepatitis _____	❑ Grass, weeds, pollen _____

Operations or serious injuries (dates) _____

Disability or chronic recurring illness_____

Dietary modifications_____

Current medications (send with instructions, nurse on duty at camp)_____

_____

Other diseases or details of above_____

Suggestions or health related information for camp personnel:

When was the date of the campers last Tetanus shot?_____

Name of family physician_____Phone_____

Name of Dentist/orthodonist_____Phone_____

Date of last physical examination_____

This health history is correct so far as I know, the person herein described has permission to engage in all prescrbed camp activities except as noted.

Signature of Parent/Guardian_____Date_____