

**WINSHAPE CAMPS FOR COMMUNITIES**  
**Camper Medical Information and Authorization Form**



Camper's Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Birthday: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_

Mother's Address \_\_\_\_\_ Bus. Phone (\_\_\_\_) \_\_\_\_\_

Father's Name \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_

Father's Address \_\_\_\_\_ Bus. Phone (\_\_\_\_) \_\_\_\_\_

**PARENTAL / LEGAL GUARDIAN AUTHORIZATION AND RELEASE:** I have voluntarily enrolled my child in a Day Camp sponsored by the entities listed below. 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, anesthesia, or surgery for my child as named above. (The Camp Director will always make every effort to consult with parents or legal guardians concerning serious health situations.) I further give permission to camp nursing and/or medical staff to administer prescription and nonprescription medication brought from home as well as those prescribed or determined necessary while at camp. I hereby release and indemnify WinShape Foundation, Inc., WinShape Camps for Communities, Connect Ministries, Inc., the \_\_\_\_\_ Church (which is the host church for the Day Camp) and all of their owners, shareholders, officers, directors, managers, employees, affiliates, sponsors and agents from any and all claims, liabilities, demands, damages and causes of action resulting or arising, directly or indirectly, from any action taken by any of them pursuant to this Camper Medical Information and Authorization Form.

Parent/Guardian Signature \_\_\_\_\_ Printed Name \_\_\_\_\_

**FOR FLORIDA RESIDENTS ONLY:** Signature must be witnessed by a Notary Public

Sworn to and subscribed before me this \_\_ day of \_\_\_\_\_, 2012.

State of Florida

County of \_\_\_\_\_ Notary Public \_\_\_\_\_ My Commission Expires: \_\_\_\_\_

(NOTARIAL SEAL)

**If neither parent can be reached in an emergency, please notify:**

1. Name: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Business Phone: (\_\_\_\_) \_\_\_\_\_

Relationship to camper: \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

2. Name: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Business Phone: (\_\_\_\_) \_\_\_\_\_

Relationship to camper: \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

**INSURANCE INFORMATION – Attach a copy of your insurance card (front and back)**

Insurance Company: \_\_\_\_\_ Name of Policy Holder: \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_ ID Number \_\_\_\_\_

Address or phone number for claims: \_\_\_\_\_

**HEALTH HISTORY – Does camper have a history of:**

Asthma	Yes	No	Behavior or emotional concerns	Yes	No	Kidney or bladder problems	Yes	No
Seizures	Yes	No	ADD	Yes	No	Cardiac problems	Yes	No
Diabetes	Yes	No	Eating disorders	Yes	No	Hepatitis	Yes	No
Heart Murmurs	Yes	No	Severe reaction to poison ivy	Yes	No	Any previous surgery	Yes	No
Orthopedic problems	Yes	No	Severe reaction to insect stings	Yes	No	Allergic to Penicillin	Yes	No
Frequent ear infections	Yes	No	Breathing problems	Yes	No	Allergic to other drugs	Yes	No
Within last 2 years	Yes	No	Bringing bee sting kit	Yes	No	Any other allergies	Yes	No
Has he/she had Chicken Pox?	Yes	No	Glasses?	Yes	No	Any diet restrictions	Yes	No
Girls: Has she menstruated?	Yes	No	Contacts?	Yes	No	Frequent headaches	Yes	No
Girls: Menstrual history normal?	Yes	No	GI or stomach problems	Yes	No		Yes	No

Please list any details related to the above health history or special instructions: \_\_\_\_\_

Please list **all** medications taken in the 30 days prior to arrival at camp: \_\_\_\_\_

List any medications to be taken at camp, including drug, dosage, method (oral, inhaler, injection, etc.), and frequency: \_\_\_\_\_