Camp use only: Insurance paid _____

CAMP STOVER CHURCH OF THE BRETHREN

LEADERSHIP REGISTRATION FORM

Use separate form for each leader – Please Print

Name of Leader _____

Address _____
Street City State Zip

Primary Phone # _____ Email _____

Emergency Contact _____
Name Relationship Phone

Is there someone at camp we can contact _____

Primary Physician Name and Phone Number _____

Insurance Carrier _____ Group/Policy # _____

Please List Special Dietary Needs _____

T-Shirt Sizes:

Adult ☐ Small ☐ Medium ☐ Large ☐ XL ☐ XXL ☐ XXXL

While attending or traveling to or from Camp Stover or special activities I become incapacitated for any reason and cannot make my own medical decisions and my emergency contact cannot be reached within a reasonable period of time, I hereby authorize and grant permission to a representative from Camp Stover to act on my behalf in granting permission for evaluation, hospitalization, to secure proper treatment, and/or order injection, anesthesia, surgery and treatment of any and all emergency medical problems as deemed necessary by the attending emergency medical team EMT/paramedics or licensed attending physician, until such time that my emergency contact can be reached.

Camp Stover may use my pictures for promotional use if they appear in the Camp pictures taken this year.

Signature _____ Date _____

NOTE: Please list all Medical conditions you have and all medications you are currently taking that you would want known in case of emergency, on the back of this form.

HEALTH HISTORY RECORD

Part I: Illness and injuries (check all that apply)

☐ Ear Infection ☐ Bleeding/Clotting Disorders ☐ Hypertension
☐ Asthma ☐ Heart Defect/Disease ☐ Seizures
☐ Diabetes ☐ Musculoskeletal Disorders ☐ Cancer
☐ Other (please specify) _____

Part II: Allergies (check all that apply and specify nature of allergic reaction)

☐ Animals _____
☐ Hay Fever _____
☐ Pollen _____
☐ Food _____
☐ Medicines/Drugs _____
☐ Insect Stings _____
☐ Plants _____
☐ Other _____

Please explain any items that are checked. Indicate any information that emergency personal should know concerning any of these health conditions:

_____

_____

Please list all past surgeries: _____

Please list all medication you are currently taking and the prescribed dosage and normal time it is taken each day (add an additional sheet if needed).

Medication	Dosage	Time