

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)

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Bleeding/Clotting Disorders | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Defect/Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Musculoskeletal Disorders | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Other (please specify) _____ | | |

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

- | | |
|--|-------|
| <input type="checkbox"/> Animals | _____ |
| <input type="checkbox"/> Hay Fever | _____ |
| <input type="checkbox"/> Pollen | _____ |
| <input type="checkbox"/> Food | _____ |
| <input type="checkbox"/> Medicines/Drugs | _____ |
| <input type="checkbox"/> Insect Stings | _____ |
| <input type="checkbox"/> Plants | _____ |
| <input type="checkbox"/> 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).

<u>Medication</u>	<u>Dosage</u>	<u>Time</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____