

FALL CREEK CHRISTIAN CAMPGROUND

CHRISTIAN YOUTH CAMP AND YOUTH RETREATS

423-881-5400 ChristianCampground.com
P O Box 717, Pikeville TN 37367

~ MEDICAL INFORMATION ~

CAMPER'S NAME: _____ AGE: _____

CHILD'S FAMILY DOCTOR: _____ PHONE: _____ - _____ - _____

EMERGENCY NUMBERS OF PARENTS OR GUARDIANS:

Father's name: _____ Mother's name: _____

Home: _____ / _____ / _____ Home: _____ / _____ / _____

Mobile: _____ / _____ / _____ Mobile: _____ / _____ / _____

Work: _____ / _____ / _____ Work: _____ / _____ / _____

Other: _____ / _____ / _____ Other: _____ / _____ / _____

ALLERGIES: _____

MEDICATION:

DOSAGE:

FREQUENCY:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

IF CAMPER HAS REACTION, EXPLAIN HOW IT AFFECTS THEM AND WHAT SHOULD BE DONE.

DATE OF LAST TETANUS SHOT: _____ ARE SHOTS UP TO DATE? _____

DOES CAMPER HAVE ANY PROBLEM THAT STAFF SHOULD BE AWARE OF? If so, please explain.

PERSON PICKING UP CAMPER AT END OF CAMP: _____

NAME OF CAMPER'S HEALTH INSURANCE CO: _____

TELEPHONE #: _____ - _____ - _____ INSURANCE CARD #: _____

WILL CAMPER HAVE HEALTH INSURANCE CARD _____ or COPY? _____

As the parent or guardian, I give my permission for my child to receive emergency medical treatment for accident or illness.

SIGNATURE OF PARENT (S) OR GUARDIAN

DATE: _____ / _____ / _____

Medical permission is in effect for a period of one year from date.