

Camper's Full Name: _____

Date of Birth: _____ Sex: M / F Race: ___ African-American ___ Hispanic ___ Caucasian ___ Other

Primary Care Provider: Name _____ Contact Number _____

Emergency Contact:

1. Name _____ Relationship _____ Number _____

2. Name _____ Relationship _____ Number _____

Allergies: Please note any allergies and describe their reactions: If there is a severe allergy please provide a doctor's note explaining the reaction and follow-up treatment. *Attach extra paper as needed to describe any necessary information.*

Environmental: _____ Food: _____

Drug: _____

No Known Drug Allergies: _____

Medications: *All prescribed medications must be brought in their original bottle with instructions and provider name, no exceptions.*

List all medications: _____

Over the Counter Medications (OTC): Listed below are the OTC medications we stock at camp. Please indicate any medications that may **NOT** be given. Any medication not listed will need to be sent in an original packaging with manufacturer's instructions.

_____ I do **NOT** consent for my child to receive OTC medications _____ I give consent for my child to receive OTC medications

- | | |
|---|------------------------------------|
| Antibiotic cream (i.e. Neosporin cream) | Ibuprofen (i.e. Advil, Motrin) |
| Hydrocortisone cream (i.e. Cortaid) | Acetaminophen (i.e. Tylenol) |
| Benadryl cream (i.e. Diphenhydramine) | Antacid (i.e. Mylanta, Tums) |
| Sunscreen & Bugspray | Cold Medications (i.e. Robitussin) |
| Benzocaine (i.e. Oragel, Chloraseptic) | Antihistamine (i.e. Benadryl) |
| Eye Drops for dryness (i.e. Saline) | Antidiarrheal (i.e. Imodium) |

All OTC medications will be given at the manufacturer's recommended dosage.

List any medications that cannot be given:

**Attach extra paper if needed*

Medical Conditions and Behavior Information: *Please list any conditions that the camper has that would affect their time at camp. Including but not limited to: behavior problems, ADD/ADHD, sleep walking, mobility problems, physical/mental disabilities.*

Camper is vaccinated against COVID: Yes _____ No _____

Is camper covered under an insurance plan? __ Yes __ No **If yes, please attach a front and back copy of the card.**

If you cannot obtain a copy please provide the information below:

Name of insurance company: _____ Address of insurance company: _____ Policy Number: _____ Name of Policyholder: _____

I, the undersigned, give my consent that, in the event that my child (or myself) is injured or taken ill while participating in an activity related to Lakeshore Camp & Retreat Center (LCRC), and in the event that my child (or I) cannot answer for themselves (myself) and the parent/gardican cannot be reached to give instructions in regards to medical care and treatment of the participant, reasonable medical care and treatment can be administered to my child (or myself) as deemed necessary by a licensed provider. I agree to hold all persons making such decisions free and harmless of any claims, demands or suites for damages arising from the giving of such consent, as long as treatment is administered by or under the supervision of a licensed physician. I also give my consent for any LCRC first aid personnel to give prescribed medication per written instructions. I further agree to pay for any medical treatment which is not covered by medical insurance. I understand that LCRC's insurance covers only accidents, no illnesses and provides secondary insurance coverage only. I also consent to the use of my child's or my image or voice taken during the course of activities at or sanctioned by LCRC for the any or all of the following: photographs, audio and/or video recordings, LCRC website, and camp brochures for the purpose of publicizing the programs of Lakeshore Camp & Retreat Center. I also agree that I will be held financially accountable for any damage purposely done to any LCRC property by the above named participant.

Signature of parent/guardian _____ Date _____