

**In order to work at Seneca Hills Bible Camp & Retreat Center, this form must be completed prior to Staff Training.**

*If any changes occur in your health status, you must report them to the Camp Nurse at Staff Training.*

Participant Information			
Last Name _____	First Name _____	MI _____	
Address _____			
City _____	State _____	Zip Code _____	
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Birthdate _____	Participant's SSN _____

Parent & Guardian Information			
Mother's Name _____			
Address (If Different Than Above) _____			
City _____	State _____	Zip Code _____	
Home Phone _____	Work Phone _____	Cell Phone _____	
Father's Name _____			
Address (If Different Than Above) _____			
City _____	State _____	Zip Code _____	
Home Phone _____	Work Phone _____	Cell Phone _____	

Emergency Contact Information			
<i>The following individual(s) may make decisions on behalf of the participant, in an emergency, if the parent or legal guardian is unavailable.</i>			
Name (s) _____			
Relationship _____			
Home Phone _____	Work Phone _____	Cell Phone _____	

Insurance Information			
<i>Please provide your insurance information as Seneca Hills Bible Camp &amp; Retreat Center only provides secondary coverage.</i>			
Insurance Carrier _____			
Carrier Phone Number _____	Policy # _____		
Policy Holder's Name _____	Policy Holder's SSN _____		

Dentist & Physician's Information			
<i>The American Camping Association (ACA) recommends campers have a physical examination by their physician within the two years prior to attending camp.</i>			
Dentist / Orthodontist _____	Office Phone Number _____		
Family Physician _____	Office Phone Number _____		
Date of Last Physical Examination _____			

Vaccination Information			
<i>While immunization records are not required, attaching a copy would assist medical staff should emergency medical treatment be necessary.</i>			
<i>Immunization Dates</i>		<i>Immunization Dates</i>	
Are the participant's immunizations up to date?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date of last Tetanus Vaccination _____	
If No, please explain: _____			
If No due to religious reasons, please complete and attach the Release & Application for Exemption from Physical Examination & Immunization Records Form available online at <a href="http://www.senecahills.com">www.senecahills.com</a> .			

Physician's Examination			
<i>The American Camping Association (ACA) recommends campers have a physical examination by their physician within the two years prior to attending camp.</i>			
_____ (Employee's Name) has had a physical examination within the past two years and <b>IS / IS NOT</b>			
able to participate in an active camp program.			
Height _____	Weight _____	Blood Pressure _____	Exam Date _____
_____			
Signature of Physician, Nurse or PA	Date	Name	

**Medical Information**

Check the following applicable box(es):

- |                                                        |                                                           |                                         |                                                  |
|--------------------------------------------------------|-----------------------------------------------------------|-----------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Headaches                     | <input type="checkbox"/> Psychiatric mental health issues | <input type="checkbox"/> Seizures       | <input type="checkbox"/> Diabetes                |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Bee sting allergy                | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Sinus/throat infections |
| <input type="checkbox"/> Sleep walking                 | <input type="checkbox"/> Bed-wetting                      | <input type="checkbox"/> Nightmares     | <input type="checkbox"/> Ear problems            |
| <input type="checkbox"/> Other (Please explain): _____ |                                                           |                                         |                                                  |

Medical Allergies:  No  Yes If Yes, Please List: \_\_\_\_\_

Food Allergies:  No  Yes Allergic Reaction Is:  Mild  Moderate  Severe

If Yes, Please List: \_\_\_\_\_

List Any Dietary Restrictions: \_\_\_\_\_

Please describe any past psychiatric treatment, counseling or hospitalization: \_\_\_\_\_

List Any Conditions Currently Being Treated: \_\_\_\_\_

Does this treatment need to continue at camp?  No  Yes If Yes, Please Describe: \_\_\_\_\_

\_\_\_\_\_

Additional health information needed in the event of a medical emergency at camp: \_\_\_\_\_

**Medication Information**

List any medications the participant is currently taking. All medications, except inhalers and epipens, must be given to the Camp Nurse at registration. This includes all over-the-counter medications.

Medication	Dosage	Frequency	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please describe any physical restrictions that would limit participation in any camp activities: \_\_\_\_\_

\_\_\_\_\_

Has the participant ever been treated at UPMC Northwest or Grove City Medical Center?  No  Yes Date \_\_\_\_\_

**Medication Authorization - Signed by Employee (18 or Older) or Parent/Legal Guardian (Under 18)**

*Below are "as needed" medications approved by our Camp Physician. Please check all medication(s) that may be administered to the below-mentioned staff member. Dosages are administered according to directions on the bottle unless a Physician orders otherwise.*

\_\_\_\_\_ (Employee's Name) may receive these "as needed" medication(s), or generic equivalents, if the Camp Nurse finds necessary.

- |                                            |                                               |                                               |                                                          |
|--------------------------------------------|-----------------------------------------------|-----------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Advil (Ibuprofen) | <input type="checkbox"/> Ambesol (Tooth Ache) | <input type="checkbox"/> Athlete's Foot Cream | <input type="checkbox"/> Chloroseptic Spray / Lozenges   |
| <input type="checkbox"/> Immodium          | <input type="checkbox"/> Maalox               | <input type="checkbox"/> Milk of Magnesia     | <input type="checkbox"/> Muscle Creams (Icy Hot, Etc.)   |
| <input type="checkbox"/> Sudafed           | <input type="checkbox"/> Swimmer's Ear        | <input type="checkbox"/> Topical Wound Care   | <input type="checkbox"/> Triaminic (Cough Syrup)         |
| <input type="checkbox"/> Tylenol           | <input type="checkbox"/> Visine               | <input type="checkbox"/> Epipen (Emergency)   | <input type="checkbox"/> Glucose (Hypoglycemic Reaction) |
| <input type="checkbox"/> Tums              | <input type="checkbox"/> Benadryl             |                                               |                                                          |

I grant permission for the designated Camp Nurse(s) of Seneca Hills to administer the "as needed" medications ordered by the Camp Physician. I am aware all personal medications must be locked in the Nurse's Station and taken according to prescription guidelines.

\_\_\_\_\_  
Signature of Parent/Legal Guardian Date Signature of Participant (If 18 or Over) Date

\_\_\_\_\_  
Name Name

