FAITH LUTHERAN VACATION BIBLE SCHOOL MEDICAL INFORMATION FORM

Camper's Name_____ Age_____ Grade entering_____

Parent/Guardian_____ Home Phone_____

Email_____ Cell Phone_____

Address_____ Birthdate_____

City_____ State_____ Zip Code_____

Siblings also attending VBS_____

Home Church_____

If Parent or Guardian is not available in an emergency notify:

Name_____ Home phone_____ Cell_____

Camper's Doctor_____ Phone_____

Any disability or recurring illness_____

Specific activities to be limited_____

Current medication or medical treatment:

_____

Dietary concerns/allergies_____

Allergic to: Penicillin___ Bee Stings___ Other (specify) _____

Anything else the Camp staff should be aware of to better care for this camper:

_____

PARENT/GUARDIAN EMERGENCY MEDICAL TREATMENT APPROVAL

EMERGENCY AUTHORIZATION: In the even I cannot be reached, I give permission to medical personnel to order X-rays, routine tests and treatment for my child. If I cannot be reached, I give permission for a qualified physician to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child.

I consent to the use of any photograph of my child in future publications of Flathead Lutheran Camp.

Signature of Parent or Guardian_____ Date_____