

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 _____

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 _____

Siblings also attending VBS _____ Home

Church _____