A Copy of the Immunization Records <u>Must</u> be attached.

Important - This Box Must Be Completed For Attendance

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. Authorization for treatment: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, and necessary transportation for me/or my child. In the event I cannot be reached in an emergecy, I hereby give persmission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child as named above. The completed forms may be photocopied for trips out of camp. I hereby release Discovery Camp, Burchfield Ministries, Believers World Outreach Church, all camp workers, and Pastors Tommy and Rachel Burchfield from all liability, personal and /or property, and grant permission to Discovery Camp nurse, Columbus Community Hospital or another medical facility to administer any necessary first aid and/or any medical treatment needed in case of an emergency. I also concent me/my child as a participant of Discovery Camp that I/they will be included in the television audience of Young Believer's Broadcast and hereby permit any and all representations made of me during camp to be used in promotional materials for the facility and it's events program(s).

Signature ______________________ Date ____/____/____

Health Care Recommendations by Licensed Physician - Only if under physician's care

I have examined the above camp applicant within the past two years. Date Examined ____/____/____

In my opinion, the above's condition ☐ does ☐ does not preclude his/her participation in an active camp program.

Height __________ Weight __________ Blood Pressure __________

The applicant is under the care of a physician for the following condition(s):

____

Current treatment (include current medications) ______________________

Explanation of any reported loss of consciousness, convulsions, or concussions: ______________________

Does applicant have epilepsy? ☐ Yes ☐ No Does applicant have diabetes? ☐ Yes ☐ No

Recommendations and Restrictions While at Camp

Any treatment to be continued at camp: ______________________

Any medication to be administered at camp (specific dosages): ______________________

Any medically prescribed meal plan or dietary restrictions: ______________________

Any allergies (food, drugs, plants, insects, ect.): ______________________

Additional health information: ______________________

Licensed Physician's Signature ______________________

Address: ______________ City: __________ St.: ____ Zip: ______ Phone: (___) ______

Date of Form Completion ____/____/____ By : ______________________

If completed by nurse or physician's assistant.