



Camp Rivervale
496 Rivervale Road
Mitchell, IN 47446
Phone: (812) 849-6824
Fax: (317) 735-9884
Email: rv@impact2018.com

**Family Camp Medical Form
2017**

Event code: RF381

Online medical form available! We encourage you to complete this medical form online instead of on paper. If you've shared your email address with us in the past, then you already have an online account. Just go to **BeACamper.com**, click on My Account, enter your email address, and click 'Forgot Password.' Or call (888) 628-2818 and ask to have your online account activated.

If you need to complete the medical form on paper, make sure this form is completed and returned to the address above by June 1st. If you receive this form after June 1st, send the completed form using the information above as soon as possible, and not later than two weeks prior to the start of the event.

Any medical forms not returned by 2 weeks before the event begins must be completed online.

Family's Insurance Information:

Are the campers covered by family medical/hospital insurance? Yes No
Policy holder's name: _____ Employer's name: _____
Relationship to campers: _____ Insurance provider: _____
Group #: _____ Policy #: _____

Alternate Emergency Contact:

Name: _____ Relationship to family: _____
Phone number: C H W (_____)_____-_____ Phone number: C H W (_____)_____-_____

Camper #1's Medical Information:

Camper's name: _____ Birthdate: ____/____/_____
Allergies: _____ Last Tetanus Shot? ____/____/_____
History of: ADD/ADHD Asthma Autism Bedwetting Diabetes Seizures
Will the camper have any medications? Yes No (If yes, list all medications below - additional on back):

Name of Medication	Dosage	Time to be Administered	Special Instructions
<i>ex 1: Clarinex tablet</i>	<i>5mg</i>	<i>Breakfast</i>	

Other medical information that will help us best serve the camper? _____

Camper #2's Medical Information:

Camper's name: _____ Birthdate: ____/____/_____
Allergies: _____ Last Tetanus Shot? ____/____/_____
History of: ADD/ADHD Asthma Autism Bedwetting Diabetes Seizures
Will the camper have any medications? Yes No (If yes, list all medications below - additional on back):

Name of Medication	Dosage	Time to be Administered	Special Instructions
<i>ex 1: Clarinex tablet</i>	<i>5mg</i>	<i>Breakfast</i>	

Other medical information that will help us best serve the camper? _____

Questions? Go to BeACamper.com or call the site at the number listed above.



Family Camp Medical Form - Continued

Camper #3's Medical Information:

Camper's name: _____ Birthdate: ____/____/____
 Allergies: _____ Last Tetanus Shot? ____/____/____
 History of: ADD/ADHD Asthma Autism Bedwetting Diabetes Seizures
 Will the camper have any medications? Yes No (If yes, list all medications below - additional on back):

Name of Medication	Dosage	Time to be Administered	Special Instructions
<i>ex 1: Clarinex tablet</i>	<i>5mg</i>	<i>Breakfast</i>	

Other medical information that will help us best serve the camper? _____

Camper #4's Medical Information:

Camper's name: _____ Birthdate: ____/____/____
 Allergies: _____ Last Tetanus Shot? ____/____/____
 History of: ADD/ADHD Asthma Autism Bedwetting Diabetes Seizures
 Will the camper have any medications? Yes No (If yes, list all medications below - additional on back):

Name of Medication	Dosage	Time to be Administered	Special Instructions
<i>ex 1: Clarinex tablet</i>	<i>5mg</i>	<i>Breakfast</i>	

Other medical information that will help us best serve the camper? _____

Camper #5's Medical Information:

Camper's name: _____ Birthdate: ____/____/____
 Allergies: _____ Last Tetanus Shot? ____/____/____
 History of: ADD/ADHD Asthma Autism Bedwetting Diabetes Seizures
 Will the camper have any medications? Yes No (If yes, list all medications below - additional on back):

Name of Medication	Dosage	Time to be Administered	Special Instructions
<i>ex 1: Clarinex tablet</i>	<i>5mg</i>	<i>Breakfast</i>	

Other medical information that will help us best serve the camper? _____

Please be sure to complete page 1 of the family camp medical form & turn in all medical form pages together.



Family Camp Medical Form - Continued

Camper #6's Medical Information:

Camper's name: _____ Birthdate: ____/____/____
 Allergies: _____ Last Tetanus Shot? ____/____/____
 History of: ADD/ADHD Asthma Autism Bedwetting Diabetes Seizures
 Will the camper have any medications? Yes No (If yes, list all medications below - additional on back):

Name of Medication	Dosage	Time to be Administered	Special Instructions
<i>ex 1: Clarinex tablet</i>	<i>5mg</i>	<i>Breakfast</i>	

Other medical information that will help us best serve the camper? _____

Camper #7's Medical Information:

Camper's name: _____ Birthdate: ____/____/____
 Allergies: _____ Last Tetanus Shot? ____/____/____
 History of: ADD/ADHD Asthma Autism Bedwetting Diabetes Seizures
 Will the camper have any medications? Yes No (If yes, list all medications below - additional on back):

Name of Medication	Dosage	Time to be Administered	Special Instructions
<i>ex 1: Clarinex tablet</i>	<i>5mg</i>	<i>Breakfast</i>	

Other medical information that will help us best serve the camper? _____

Camper #8's Medical Information:

Camper's name: _____ Birthdate: ____/____/____
 Allergies: _____ Last Tetanus Shot? ____/____/____
 History of: ADD/ADHD Asthma Autism Bedwetting Diabetes Seizures
 Will the camper have any medications? Yes No (If yes, list all medications below - additional on back):

Name of Medication	Dosage	Time to be Administered	Special Instructions
<i>ex 1: Clarinex tablet</i>	<i>5mg</i>	<i>Breakfast</i>	

Other medical information that will help us best serve the camper? _____

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Family Camp Medical Form - Continued

Camper #9's Medical Information:

Camper's name: _____ Birthdate: ____/____/____
 Allergies: _____ Last Tetanus Shot? ____/____/____
 History of: ADD/ADHD Asthma Autism Bedwetting Diabetes Seizures
 Will the camper have any medications? Yes No (If yes, list all medications below - additional on back):

Name of Medication	Dosage	Time to be Administered	Special Instructions
<i>ex 1: Clarinex tablet</i>	<i>5mg</i>	<i>Breakfast</i>	

Other medical information that will help us best serve the camper? _____

Camper #10's Medical Information:

Camper's name: _____ Birthdate: ____/____/____
 Allergies: _____ Last Tetanus Shot? ____/____/____
 History of: ADD/ADHD Asthma Autism Bedwetting Diabetes Seizures
 Will the camper have any medications? Yes No (If yes, list all medications below - additional on back):

Name of Medication	Dosage	Time to be Administered	Special Instructions
<i>ex 1: Clarinex tablet</i>	<i>5mg</i>	<i>Breakfast</i>	

Other medical information that will help us best serve the camper? _____

Camper #11's Medical Information:

Camper's name: _____ Birthdate: ____/____/____
 Allergies: _____ Last Tetanus Shot? ____/____/____
 History of: ADD/ADHD Asthma Autism Bedwetting Diabetes Seizures
 Will the camper have any medications? Yes No (If yes, list all medications below - additional on back):

Name of Medication	Dosage	Time to be Administered	Special Instructions
<i>ex 1: Clarinex tablet</i>	<i>5mg</i>	<i>Breakfast</i>	

Other medical information that will help us best serve the camper? _____

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