



IMPACT 2818: Outdoor Ministries

of the United Methodist Churches of Indiana



Pine Creek Camp
2218 E. 700 N.
Pine Village, IN 47975
Phone: (765) 385-2260
Fax: (317) 333-6603
Email: pc@impact2818.com

Family Camp Medical Form 2018

Event code: _____

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.



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? _____



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? _____



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? _____