IMPACT 2818: Outdoor Ministries
of the United Methodist Churches of Indiana

Camp Lakewood
6815 S. 1100 E.
Wolcottville, IN 46795
Phone: (260) 351-2331
Fax: (317) 216-6397
Email: lw@impact2818.org

Family Camp Medical Form 2020

Event start date: _____

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. Simply go to **Impact2818.org/myaccount**, 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 both sides of this form are 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
ex 1: Clarinex tablet	*5mg*	*Breakfast*	

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
ex 1: Clarinex tablet	*5mg*	*Breakfast*	

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

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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
ex 1: Clarinex tablet	*5mg*	*Breakfast*	

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
ex 1: Clarinex tablet	*5mg*	*Breakfast*	

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
ex 1: Clarinex tablet	*5mg*	*Breakfast*	

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.

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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
ex 1: Clarinex tablet	*5mg*	*Breakfast*	

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
ex 1: Clarinex tablet	*5mg*	*Breakfast*	

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
ex 1: Clarinex tablet	*5mg*	*Breakfast*	

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
ex 1: Clarinex tablet	*5mg*	*Breakfast*	

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
ex 1: Clarinex tablet	*5mg*	*Breakfast*	

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
ex 1: Clarinex tablet	*5mg*	*Breakfast*	

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

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