



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 2022 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](https://www.impact2818.org/myaccount), enter your email address, and click 'Forgot Password.' Or call (888) 628-2818 for assistance.

If you need to complete the medical form on paper, make sure this form are completed and returned to the address 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.

Remember, upon registration you agreed to assess yourself/child/household for symptoms of COVID-19 for the 14 day period before arrival at camp. For a list of symptoms, please visit [cdc.gov/covid-19](https://www.cdc.gov/covid-19).

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? _____



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? _____