YOUTH CAMP HEALTH HISTORY
CAMPER

Child's Name: _____

Current residence: _____

_____

EMERGENCY CONTACT INFORMATION:

Emergency Contact
(Parent or Legal Guardian): _____ Phone: _____

2nd Emergency Contact
(Other than Parent Above): _____ Phone: _____

Primary Care Physician or
other provider of medical care: _____ Phone: _____

HEALTH INFORMATION:

Are there any health problems including physical, psychiatric, or behavioral problems of which we need to be aware? ☐ NO

☐ YES, Explain: _____

_____

_____

_____

Are there any medications, dietary restrictions, allergies, or special needs that we need to be aware of to ensure that your child's camp experience is positive? ☐ NO

☐ YES, Explain: _____

_____

_____

_____

IMMUNIZATION INFORMATION:
Must list current residence above.

For campers who currently reside **within** the United States, a United States territory, or the District of Columbia: Does the camper have any immunization exemptions because of a parental or guardian objection or medical contraindication? ☐ NO

☐ YES, List: _____

For campers who reside **outside** the United States, a United States territory, or the District of Columbia: Attach record of vaccination or immunity on Department form MDH-896.

_____

Parent or Legal Guardian's Signature Date

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:
(1) Complete all items on this side of the form. Sign and date where indicated.
(2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name _____ Birth Date _____
Last First

Enrollment Date _____ Hours & Days of Expected Attendance _____

Child's Home Address _____
Street/Apt. # City State Zip Code

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		Place of Employment: _____ W:	C:	H:
		Place of Employment: _____ W:	C:	H:

Name of Person Authorized to Pick up Child *(daily)* _____
Last First Relationship to Child

Address _____
Street/Apt. # City State Zip Code

Any Changes/Additional Information _____

_____

ANNUAL UPDATES _____ _____ _____ _____
(Initials/Date) *(Initials/Date)* *(Initials/Date)* *(Initials/Date)*

When parents/guardians cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt. # City State Zip Code

2. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt. # City State Zip Code

3. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt. # City State Zip Code

Child's Physician or Source of Health Care _____ Telephone _____

Address _____
Street/Apt. # City State Zip Code

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian _____ Date _____

INSTRUCTIONS TO PARENT/GUARDIAN:

(1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
(2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: ______________________________ Date of Birth: ______________

Medical Condition(s): ____

____

Medications currently being taken by your child: ______________________________

____

Date of your child's last tetanus shot: ______________________________

Allergies/Reactions: ____

____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: ______________________________

____

(2) If signs/symptoms appear, do this: ______________________________

(3) To prevent incidents: ______________________________

____

- -

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: ______________________________

____

____

____

COMMENTS: ____

____

____

____

____

Note to Health Practitioner:

If you have reviewed the above information, please complete the following:

______________________________ ______________________________
Name of Health Practitioner Date

______________________________ (____)__________________________
Signature of Health Practitioner Telephone Number

bethel christian academy

Dear Parent or Guardian,

Situations arise at times in which an unforeseen life-threatening allergic reaction has occurred at school. In the past, the only recourse for the school was to call 911. New regulations allow schools to have Discretionary Medication (i.e., EpiPen) on site for use in such situations.

At the bottom of this letter is a sign-off that provides the BCA delegating nurse with your consent to have a BCA Medication Technician or other trained staff member administer the EpiPen in case of an unforeseen allergic reaction while your child is at school. **This form must be filled out each summer.**

Whenever a life-threatening reaction occurs, the school will call 911. The Discretionary Medication is designed to help a student when a life-threatening reaction has occurred at school and while waiting for the EMS to arrive.

Your consent must be obtained before any medication is given to your child. Only the RN may approve the administration of this medication by a BCA Medication Technician or other staff member in accordance with established protocols.

Please sign at the bottom of this letter and indicate your approval or not for the administering of the EpiPen in the case of an allergic reaction.

- - - - - - - - - - - - - - -

Consent for Administration of Discretionary Medications

Student's Name _____ Grade _____

___ I give my permission for my student to receive the EpiPen as deemed necessary by the delegating nurse.

___ I do NOT want the EpiPen to be given to my student at school.

Parent/Guardian Information:

Name: _____ Home # _____ Cell # _____

Parent/Guardian Signature _____ Date _____

8455 Savage Guilford Road P.O. Box 406 Savage, Maryland 20763
Office: 301-725-4673 Fax: 301-617-9277 Website: www.bethelchristianacademy.com

bethel christian academy

Digital Media Release

I do hereby grant or deny permission to Bethel Christian Academy to use the image of my child, _____, as marked by my selection below. Such use includes the display, distribution, publication, transmission, or otherwise use of photographs, images, and/or video taken of my child for use in materials that include, but may not be limited to, printed materials such as brochures and newsletters, videos, and digital images such as those on the Bethel Christian Academy website.

☐ I deny permission to use my child's image at all.

☐ I give permission for my child's image to be used in print, video, and digital media. I agree that these images may be used by Bethel Christian Academy as described above without further notification.

Parent/Guardian Signature: _____ Date: _____

Transportation Release

I do hereby grant permission to Bethel Christian Academy to transport my child, _____, to and from all campuses, for various school related activities (i.e. program practices and Middle School P.E.). I release Bethel Christian Academy and its officers and agents from all liability for accidental injury to my student while in transit. I additionally release Bethel Christian Academy from financial liability for any loss of my student's property during or following transit.

Parent/Guardian Signature: _____ Date: _____

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HIPAA Authorization

Student Name: _____ Date of Birth: _____

In accordance with government HIPAA regulations, I hereby authorize Bethel Christian Academy's health officials to share health information and health history with the other staff members on a need to know basis. This includes the Homeroom and Special teachers that have the student in their class. The purpose of this disclosure is for the teachers to be prepared in advance for any medical emergencies.

The health information to be disclosed will be from the Health Inventory, Emergency Card, Medical Protocols, Medical Order form, and Immunizations records.

I also authorize release of medical information to _____ (name of doctor) for the treatment of my student while attending Bethel Christian Academy.

This medical information will be from the health record that is maintained in the health room by the medical staff.

****

Authorization

This authorization is valid for one school year. It is valid from August to June. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I also understand that this information is released to help with the treatment of my student while attending Bethel Christian Academy.

_____ _____

Parent or Guardian Signature Date

_____ _____

Student Name Teacher / Grade

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