**IF POSSIBLE PLEASE REGISTER ONLINE AT bciowa.org/iu2017**

IMPACT - 2017

STUDENT MEDICAL RELEASE FORM

Last Name First Name

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Emergency Contact Person Relationship to Student

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Emergency Preferred Phone Emergency Alternate Phone

-- --

Emergency Contact Email



Secondary Emergency Contact Person Relationship to Student  

Secondary Emergency Preferred Phone Secondary Emergency Alternate Phone

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Secondary Emergency Contact Email

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Physician



Physician Phone Number Date of Last Tetanus Immunization

-- //

Name of Medical Insurance Company Phone Number

 --

Primary Insurance Subscriber’s Name

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Policy Number Is prior notification required for emergency health care at a hospital?

 Y N

Phone number for prior notification for hospital care.

--

**Please attach a copy of your insurance card**

**Please notify nurse of any medical changes upon arrival at IMPACT including antibiotics/accidents.**

STUDENT MEDICAL AND SURGICAL WAIVER

To be completed by the parent(s) and/or guardian(s) of participants under 18 years of age.

I, parent and/or legal guardian of , a minor, hereby acknowledge that said minor is presently under my care, custody, and control. I hereby give my child, the said minor, my express permission to attend IMPACT 2017 between the dates of July 10, 2017 and July 15, 2017. I further expressly grant my permission for my child to participate in all activities of said event.

I have listed said minor’s physical or medical problems that may need attention. In the event there arises an emergency, necessitating medical or surgical attention, I hereby consent and give my permission to the Baptist Convention of Iowa, or its representatives, or any Iowa Southern Baptist Association, or the event sponsors, or any attending physician, to make such decisions and to perform such medical treatments and/or surgery upon said minor which may, in their sole discretion, be necessary and proper under the circumstances.

I do release, acquit, discharge, and covenant to hold harmless the IMPACT staff, the Baptist Convention of Iowa, or its representatives, or any Iowa Southern Baptist Association, or the event sponsors, or the college upon whose campus IMPACT is being conducted, from any and all actions, damages, liabilities arising out of the treatment of any sickness or accident incurred by said minor at IMPACT from July 10-15, 2017.

Also, I understand that this student may be photographed or videotaped during normal event activities and these photos/videos may be used in promotional materials.

**🢥Parent/Guardian Signature: Date:**

STUDENT MEDICAL RELEASE FORM

List ALL KNOWN Allergies (Food/Drugs/Other)

These non-prescription medications may be stocked in the nurse’s station and used as needed to manage illness or injury. Please mark any that **SHOULD NOT BE GIVEN** to this student.

** OKAY TO GIVE ALL LISTED**

Tylenol (acetaminophen) Ibuprofen (Advil, Motrin) Tums (or generic) Oral Benadryl

Hydrocortisone Cream (anti-itch) Cough Drops Antibiotic Cream

 Other common medicine this student should NOT be given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**­Will the student have medicines to be take while at camp? (Including prescription and non-prescription medicines). Y N**

Medication #1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When will medication #1 need to be taken? (check all that apply)

Breakfast Time Lunch Time Dinner Time Bed Time Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication #2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When will medication #2 need to be taken? (check all that apply)

Breakfast Time Lunch Time Dinner Time Bed Time Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication #3 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When will medication #3 need to be taken? (check all that apply)

Breakfast Time Lunch Time Dinner Time Bed Time Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication #4 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When will medication #4 need to be taken? (check all that apply)

Breakfast Time Lunch Time Dinner Time Bed Time Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication #5 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When will medication #5 need to be taken? (check all that apply)

Breakfast Time Lunch Time Dinner Time Bed Time Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication #6 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When will medication #6 need to be taken? (check all that apply)

Breakfast Time Lunch Time Dinner Time Bed Time Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Medications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS BY CIRCLING Y FOR YES - N FOR NO**

**Y N** This student has been diagnosed with Attention Deficient Disorder or ADD/HD?

**Y N** This student has a psychiatric condition, such as depression, OCD, panic/anxiety disorder.

**Y N** This student has an emotional health concern.

**Y N** This camper has a learning disability/challenge.

**Y N** This student has seen or is seeing a professional to address mental/emotional health needs.

**Y N** Please list any other medical conditions or special needs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🢥**Parent/Guardian Signature**:  **Date:\_\_\_\_\_\_\_\_\_\_\_**

🢥**Parent/Guardian Signature: Date:**