



Oak Hill Christian Service Camp

8451 Oak Hill Camp Road
Mechanicsville, Virginia 23111
804-779-3050
www.oakhillcamp.org
Glenn Foster, Camp Manager

Junior Counselor Medical Information

Name: _____ Social Security #: _____

Parent/Guardian Name(s): _____

Phone: (H) _____ (W) _____ (C) _____

Additional Contact: _____ Relationship to child: _____

Additional Contact Phone: (H) _____ (W) _____ (C) _____

Family Physician: _____

Physician's Address: _____

Physician's City/State/Zip: _____ Phone: _____

Insurance Carrier/Plan Name: _____

Group #: _____ Social Security or Identification #: _____

Name of Insured: _____ Relationship to child: _____

Please check if child has had any of the following conditions:

- | | | | | |
|---|---|--|--|---------------------------------------|
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sleep Walking | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Bed Wetting |
| <input type="checkbox"/> Poison Oak/Ivy | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Headaches | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Night Terror | <input type="checkbox"/> Fainting | <input type="checkbox"/> Hospitalized | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> ADD or ADHD | |
| <input type="checkbox"/> Problems with joints (knees, ankles) | <input type="checkbox"/> Emotional difficulties for which professional help sought | | | |
| <input type="checkbox"/> Knocked Unconscious | <input type="checkbox"/> Experienced dizziness or chest pain during or after exercise | | | |
| <input type="checkbox"/> Other _____ | | | | |

Please give month and year of the last immunization/booster or attach a copy of the official record (a current tetanus shot is required):

_____ Tetanus _____ Measles/Mumps/Rubella _____ Diphtheria/Pertussis (DtaP/DT)
_____ Chicken Pox _____ Meningitis _____ Hepatitis A _____ Hepatitis B

Special Medications

Please attach a note indicating type of medication and dosage and if there are any known physical restrictions or limitations or allergies for this child.



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Junior Counselor Medical Information (continued)

Permission to Treat Common Ailments

I give permission for the following medications to be administered for common ailments:

- | | | | | |
|---|---------------------------------------|---|---|--|
| <input type="checkbox"/> Advil | <input type="checkbox"/> Tylenol | <input type="checkbox"/> Benadryl | <input type="checkbox"/> Bee Sting Swabs | <input type="checkbox"/> 1% Hydrocortisone Cream |
| <input type="checkbox"/> Aloe Vera Gel | <input type="checkbox"/> Anbesol | <input type="checkbox"/> Liquid Cough Suppressant | <input type="checkbox"/> Sunscreen | |
| <input type="checkbox"/> Cough Drops | <input type="checkbox"/> Pepto Bismol | <input type="checkbox"/> Antibiotic Cream | <input type="checkbox"/> Sudafed Decongestant | |
| <input type="checkbox"/> Saline Eye Drops | <input type="checkbox"/> Tums | | | |

Parent/Guardian Permission Medical Release Valid 6/1/11 – 5/31/12

I give my child _____ permission to attend and participate in this program.

I certify that the child named on this medical form is in good physical condition, with no organic weakness or problem which would make it unsafe for him/her to engage in an athletic program such as competitive games, running, hiking, and aquatic activities. I also certify that the Camp Manager, Camp Dean, or Camp Nurse has my permission to sign any consent forms necessary for needed medical aid or hospitalization. I hereby give permission to medical personnel selected by the camp to order x-rays, routine tests, or other treatment; to release any records necessary for insurance purposes; to release a diagnosis and prescription to camp staff; and to provide or arrange any necessary related transportation for my child. If I cannot be contacted, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization. This completed form may be photocopied for trips off of the camp premises.

Signed: _____

Date: _____