Camp Shetek Health Form

Name of Camper:	Parent or Guardian:	
Address:	City:	State:
Work Phone: ( ) --	Cell Phone: ( ) --	Home Phone: ( ) --
Email Address:	Gender: ☐ Boy ☐ Girl	Date of Birth: __ __ / __ __ / __ __ __ __

Any special health problems or allergies?

Any special dietary needs?

Any special restrictions to physical activities?

Any other health concerns you may have or want us to know about?

Insurance information:

Is camper covered by family health insurance? ☐ Yes ☐ No	Health insurance provider:	Policy or ID number:

PERMISSION and MEDICAL RELEASE

"I hereby give my permission for my son / daughter (circle one), _____ _____ to attend Minnesota Valley Lutheran Bible Camp (Camp Shetek). IN THE EVENT OF AN EMERGENCY, I authorize first-aid treatment by the camp staff.

In the event that I cannot be contacted, I authorize a licensed physician, chosen by the Camp Director, to provide the necessary treatment, which may include injections, hospitalization, anesthesia and/or surgery. I am fully aware that any medical expenses will be covered by my own family Health Insurance. "I will not hold the Camp Staff or the Camp Director liable for any of these expenses."

Parent / Guardian Signature:	Date:

Questions? Call (507)327-7222 or Email mvlcamp@gmail.com

Camp Shetek Medication Release

To be completed by parent:

I request that the above medication be given at camp as prescribed by our physician.

Parent / Guardian Signature:	*Date:*

The signature of both parent and physician are required for medication to be given at camp. Medication needs to be supplied in the original prescription bottle. The label must include the name and phone of the pharmacy, camper's name, name of prescribing physician, directions for use, medication identification number, and the date of original issue or renewal.

Please clearly mark all non-prescription medication with the name of the camper and any special instructions as to its usage.

Name of Camper:	*Date of Birth:* __ __/ __ __/ __ __ __ __
Parent or Guardian:	*Phone Number:* ( ) --
Emergency contact:	*Phone Number:* ( ) --
Relationship of Emergency contact:	

Please ask your physician to complete this section:

Medication name:	*Medication 2 name:*
Time of administration:	*Time of administration:*
Dosage and administration route:	*Dosage and administration route:*
Purpose of medication:	*Purpose of medication:*
Special Precautions:	*Special Precautions:*

Physicians Signature:	*Date:*	*Phone Number:* ( ) --

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