



Sugar Creek Bible Camp
 13141 Sugar Creek Bible Camp Rd Ferryville, WI 54628
 Phone: 608-734-3113 Email: office@sgrcreek.org

2024 Health History and Permission Form

This form is for campers who did NOT use the online registration system.

Wisconsin State Health Code – State law requires that this form, completed and signed by a parent or guardian, be on file at the camp for the participant to attend a residential camp program. Although regular medical check-ups are recommended, a physician's signature is not required on this form.

NAME OF CAMPER _____ **Grade (Fall 2024)** _____ **Gender** _____

Birthdate _____ **Current Age** _____ **Program and Week Attending** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Home or Cell Phone (_____) _____ **Cell or Work Phone (_____)** _____

Parent/Guardian Name(s) _____

Parent/Guardian address -if different from camper _____

<p align="center">HEALTH HISTORY</p> <p>If none apply, check here <input type="checkbox"/></p> <p>Diseases/Conditions: <i>Please list approximate dates.</i></p> <p><input type="checkbox"/> Ear infections _____</p> <p><input type="checkbox"/> Heart Condition(s) _____</p> <p><input type="checkbox"/> Seizures _____</p> <p><input type="checkbox"/> Diabetes _____</p> <p><input type="checkbox"/> Bleeding Disorders _____</p> <p><input type="checkbox"/> Asthma _____</p> <p><input type="checkbox"/> Chicken Pox _____</p> <p><input type="checkbox"/> Hepatitis _____</p> <p><input type="checkbox"/> Fractures _____</p> <p><input type="checkbox"/> Operations _____</p> <p>_____</p> <p><input type="checkbox"/> Other _____</p> <p>_____</p>	<p align="center">MEDICAL ALLERGIES</p> <p>If none apply, check here <input type="checkbox"/></p> <p align="center"><u>Life Threatening?</u></p> <p><input type="checkbox"/> Bee Stings <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Penicillin <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Other Meds: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>_____</p> <p>_____</p>	<p align="center">EMERGENCY INFORMATION</p> <p>Emergency Contact Person-<i>If parents/guardians cannot be reached.</i></p> <p>_____</p> <p>Phone (_____) _____</p> <p>Family Doctor _____</p> <p>Clinic _____</p> <p>Phone (_____) _____</p>
<p align="center">FOOD ALLERGIES</p> <p>If none apply, check here <input type="checkbox"/></p> <p align="center"><u>Life Threatening?</u></p> <p><input type="checkbox"/> Dairy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Eggs <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Seafood <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Peanuts <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Tree Nuts <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Gluten <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Other foods: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>_____</p> <p>_____</p>	<p align="center">TETANUS IMMUNIZATIONS</p> <p align="center">Tetanus/Whooping Cough (DPT, TD or Tdap)</p> <p>Date of most recent immunization _____</p> <p>Type? _____ or write none _____</p> <p>Are your child's school-required immunizations up-to-date? ____ Yes? or ____ No? If immunizations are not current, please explain in the Additional Information section on back.</p> <p>Please <u>attach</u> a detailed description of any chronic condition, any restrictions or limitations, and directions for care in the Additional Information section on the back.</p>	

Over the Counter Medication: The following medications are kept on hand at camp. Please do not bring any of the medications listed below **except for a chronic, daily condition.** **Please check the box by all the medications which our health care professional may administer to your child as needed.** All medications are given according to the instructions on the medication packaging and per medical protocol.

- Acetaminophen Ibuprofen Benadryl (or generic) Antihistamines Cold Medicines Antacids or stomach aids

Prescription Medication: In order for our health care staff to administer PRESCRIPTION MEDICATION to a participant, Wisconsin law requires that the bottle **MUST** be labeled with the participant's name, name of medication, dosage, frequency and route of administration, name of prescribing physician, date prescribed, possible side effects and precautions. Please list **any** medications (**prescription or OTC**) your child will need to have administered at camp. You will also speak with the camp nurse or doctor at Sunday or Wednesday check-in.

Medication Name	Treatment for?	How and when should it be administered? (You may also attach instructions) *



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Parent/Guardian Authorization: This health form is correct as far as I know and the person herein described has my permission to engage in all activities, except those noted on this form. If I cannot be reached in the event of a medical emergency, I give my permission to the health care provider selected by the camp to give necessary medical treatment to the person listed on the previous page.

Medical Release: In consideration of acceptance to Sugar Creek Bible Camp, I indemnify and hold harmless Sugar Creek Bible Camp, its owners, agents, associates, and staff from any and all liability, claims, damage, injury or illness sustained by my camper.

Parent or Legal Guardian Signature (required):

Signature: _____ Date: _____

Sugar Creek Bible Camp Insurance Policy:

I understand that the camp insurance policy is strictly secondary coverage. **Yes** _____ **Initials**

Please check here ONLY if your camper is NOT covered by health insurance. _____ **Initials**

Media Release: I give my permission for photographic and/or video images of my camper to be used in future Sugar Creek Bible Camp promotional materials, web-based media, or publications. I understand Sugar Creek will not use my child's name or personal information. **Yes** **No** _____ **Initials**

***Additional Information regarding chronic condition(s), medications, or your child's overall health:**

Please mail or email this form to camp at least 2 weeks prior to your child's week of camp.