CLEAR CREEK
CHURCH OF CHRIST

MEDICAL HISTORY & RELEASE FORM

Effective Dates: June 1, 2026 through May 31, 2027

Name: _____ Birthday _____ M / F (circle one) 2025-2026 Grade _____
Last First Middle

Address: _____ City _____ State _____ Zip _____

Medical Insurance Co. _____ Policy # _____ Name of Policyholder: _____

Mother's Name _____ Phone: Cell _____ Work _____

Father's Name _____ Phone: Cell _____ Work _____

Emergency Contact _____ Phone: Cell _____ Work _____

PCP Physician _____

Dentist _____

MEDICAL HISTORY

Check the following areas of concern for this student. If necessary, add another page with details:

1. For your child's safety and our knowledge, is your student a:
   ☐ good swimmer ☐ fair swimmer ☐ non-swimmer

2. Does your child suffer from, or has ever experience, or is being treated currently for any of the following:
   ☐ asthma ☐ epilepsy/seizure disorder ☐ heart trouble
   ☐ diabetes ☐ frequently upset stomach ☐ physical handicap

3. Date of last tetanus shot: _____

4. Does your child wear: ☐ glasses ☐ contact lenses

5. Please list and explain any major illnesses the child experienced during the last year:

   _____
   _____
   _____

   Additional comments: _____
   _____
   _____
   _____

   Should this child's activities be restricted for any reason? Please explain. _____
   _____
   _____
   _____

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ALLERGIES

Please note any allergies and describe their reactions: If there is a severe allergy, please provide a doctor's note explaining the reaction and follow-up treatment. *Attach extra paper as needed to describe any necessary information.*

Environmental:_____ Food: _____

Drug: _____ No Known Drug Allergies:_____

Medications

All prescribed medications must be brought in the original bottle with instructions and provider name. List all medications with dosage instructions: _____

_____

_____

Over the Counter Medications (OTC)

Listed below are the OTC medications we stock at camp. Please indicate any medications that may **NOT** be given. Any medication not listed will need to be sent in original packaging with manufacturer's instructions. Initial below:

_____ I consent for my child to receive OTC medications. _____I do **NOT** consent for my child to receive OTC medications.

- ☐ Antibiotic cream (i.e. Neosporin)
- ☐ Hydrocortisone cream (i.e. Cortaid)
- ☐ Benadryl cream (i.e. Diphenhydramine)
- ☐ Sunscreen & Bug spray
- ☐ Benzocaine (i.e. Oragel, Chloraseptic)
- ☐ Eye Drops for dryness (i.e. Saline)
- ☐ Ibuprofen (i.e. Advil, Motrin)
- ☐ Acetaminophen (i.e. Tylenol)
- ☐ Antacid (i.e. Mylanta, Tums)
- ☐ Cold Medications (i.e. Robitussin)
- ☐ Antihistamine (i.e. Benadryl)
- ☐ Antidiarrheal (i.e. Imodium)

List any medications that cannot be given:

_____

All OTC medications will be given at the manufacturer's recommended dosage.

**Attach extra paper if needed*

_____ *I agree to release any medications (OTC or RX) and dosage instructions to trip nurse or church staff. I understand by NOT adhering to this policy, I accept full responsibility for any due harm to my child or others.*

Medical Conditions and Behavior Information

Please list any conditions that the child has that would affect their time at activities including but not limited *to behavior problems, ADD/ADHD, sleep walking, mobility problems, physical/mental disabilities.*

_____

_____

_____

_____

I, the undersigned, give my consent that, in the event that my child (or myself) is injured or taken ill while participating in an activity related to Clear Creek Church of Christ, and in the event that my child (or I) cannot answer for themselves (myself) and the parent/guardian cannot be reached to give instructions in regards to medical care and treatment of the participant, reasonable medical care and treatment can be administered to my child (or myself) as deemed necessary by a licensed provider. I agree to hold all persons making such decisions free and harmless of any claims, demands or suits for damages arising from the giving of such consent, as long as treatment is administered by or under the supervision of a licensed physician. I also give my consent for any Church first aid personnel to give prescribed or OTC medications per written instructions. I further agree to pay for any medical treatment which is not covered by medical insurance. I understand that Church's insurance covers only accidents, no illnesses and provides secondary insurance coverage only.

Signature of parent/guardian _____ Date _____