

\*Must be filled in.

**EMERGENCY MEDICAL RELEASE FORM 2024**

\*Last Name \_\_\_\_\_ \*First Name \_\_\_\_\_

\*Male: \_\_\_\_\_ Female: \_\_\_\_\_ \*Birth Date: \_\_\_\_\_

\*Camper's Address \_\_\_\_\_

\*Parents Name: \_\_\_\_\_

\*Address: \_\_\_\_\_

Parents Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ \*Cellular: \_\_\_\_\_

Health Information:

\*General- Is Youth subject to: (if "yes" explain)

- \_\_\_\_\_ Yes      \_\_\_\_\_ No      Fainting
- \_\_\_\_\_ Yes      \_\_\_\_\_ No      Sleep Walking
- \_\_\_\_\_ Yes      \_\_\_\_\_ No      Upset Stomach
- \_\_\_\_\_ Yes      \_\_\_\_\_ No      Other

\*Reactions/ Allergies- Is Youth subject to: (if "yes"- explain and list medication)

- \_\_\_\_\_ Yes      \_\_\_\_\_ No      Penicillin
- \_\_\_\_\_ Yes      \_\_\_\_\_ No      Other Drugs
- \_\_\_\_\_ Yes      \_\_\_\_\_ No      Bee Sting
- \_\_\_\_\_ Yes      \_\_\_\_\_ No      Poison Ivy, etc.
- \_\_\_\_\_ Yes      \_\_\_\_\_ No      Other Allergies
- \_\_\_\_\_ Yes      \_\_\_\_\_ No      \_\_\_\_\_

\*Medications/ Conditions- Is Youth subject to (if "yes"- explain and list medication)

- \_\_\_\_\_ Yes      \_\_\_\_\_ No      Asthma
- \_\_\_\_\_ Yes      \_\_\_\_\_ No      Bronchitis
- \_\_\_\_\_ Yes      \_\_\_\_\_ No      Diabetes
- \_\_\_\_\_ Yes      \_\_\_\_\_ No      Heart Condition
- \_\_\_\_\_ Yes      \_\_\_\_\_ No      Sight/ Hearing
- \_\_\_\_\_ Yes      \_\_\_\_\_ No      Wears Contacts
- \_\_\_\_\_ Yes      \_\_\_\_\_ No      Serious Illness or injury in the last ten years

THIS SECTION IS OPTIONAL

I give permission for medical information to be shared with Camp Staff that are directly involved with your youth.

(Initial) \_\_\_\_\_

Date of Last Tetanus Shot: \_\_\_\_\_

Please indicate ANYTHING else that adult leaders should know to help deal with any medical situation that may arise:

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\*Emergency Information (please include photocopy of insurance card)

\*Health Insurance Co. \_\_\_\_\_ Policy Number \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone Number \_\_\_\_\_

\*Other Contact \_\_\_\_\_ Relationship \_\_\_\_\_

\*Home Phone \_\_\_\_\_ \*Cellular: \_\_\_\_\_

**\*AUTHORIZATION TO CONSENT TO MEDICAL AND DENTAL CARE**

I, the undersigned parent and/or legal guardian of \_\_\_\_\_, a minor under age 18, do hereby authorize the camp nurse, Robert Milkert, or an authorized member of Lutheran Youth Ministries to consent to:

1. Medical, surgical, and dental care for such minor child;
2. Consent to any diagnostic tests, medical, surgical, or dental procedure of treatment as may providing care for such minor child;
3. and on my behalf to:
  - a. employ physicians, surgeons, dentists, nursed, and other health care personnel as may be deemed necessary for such minor child,
  - b. admit such minor child to any hospital, clinic, emergency room, laboratory, or other health care or diagnostic facility for examination, treatment, surgery, or care,
  - c. sign all necessary consents and authorization.
4. Any non-emergency first aid, including the administration of:

_____ Yes	_____ No	Acetaminophen (Tylenol or similar pain reliever)
_____ Yes	_____ No	Pepto Bismol/ Imodium AD
_____ Yes	_____ No	Antacid (Tums, Maalox)
_____ Yes	_____ No	Decongestant (Sudafed)
_____ Yes	_____ No	Benadryl

I am required by Doctor \_\_\_\_\_ the prescribing physician, to take the following medication during Camp:

1. Medication: \_\_\_\_\_ Possible Reactions: \_\_\_\_\_
2. Medication: \_\_\_\_\_ Possible Reactions: \_\_\_\_\_
3. Medication: \_\_\_\_\_ Possible Reactions: \_\_\_\_\_
4. Medication: \_\_\_\_\_ Possible Reactions: \_\_\_\_\_

**Medications are to be in the original container with directions for dosage clearly legible on label.**

It is understood that this authorization is given in advance of the occurrence of any condition or situation that would necessitate any such medical, surgical, or dental care being required, and this is given to provide authority to obtain such care if it should be required. This document shall be in effect for the dates of July 21<sup>st</sup>- July 26<sup>th</sup>, 2024

IN WITNESS WHEREOF, I have executed the Authorization to consent to Medical and Dental Care:

This \_\_\_\_\_ day of \_\_\_\_\_, 2024

State of \_\_\_\_\_ Parent/ Legal Guardian \_\_\_\_\_  
 \_\_\_\_\_ County Parent/Legal Guardian \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_, 2024, before me, a Notary Public, personally appeared and known to be the person who executed the above Consent and stated that it was executed as their free act and deed.

(SEAL)

\_\_\_\_\_  
Notary Public