

The Master's Inn Medical Consent Form

**Please send these forms with your deposit and signed contract to make reservations.
TMI will file this in their permanent records and will not be returned.**

Camper Name: _____
Last First MI

Home Address: _____
Street Address

City State Zip

Gender: Male Female

Custodial Parent / Guardian: _____

Home Address: _____

(If different from above) Street Address

City State Zip

Home Phone: _____

Cell Phone: _____

If not available in an emergency notify:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Insurance Information

Camper does not have health care coverage at this time.

Camper does not have health care coverage at this time.

Insurance Provider _____

Address: _____

Phone #: _____

Policy Holder: _____ Policy #: _____

Group # _____ Effective Date: _____

Physician _____ Phone #: _____

Church: _____

Camp Dates: _____

Camp: Children Youth
Grades: 3-6 Grades: 7-12

Grade of upcoming school year: _____

Choose One

This individual is bringing medication
(Including non-prescription)

This individual is not bringing any
kind of medication

OFFICE USE ONLY
Reviewed by Camp Staff
Initial: _____ Date: _____

**No one is allowed at The Master's Inn without
completing both sides of this form in its entirety**

(OVER)

Medication Information

Over-the-counter medications such as Tylenol, Ibuprofen or Benadryl are supplied by the camp. Please do not send extras to camp. We do not stock aspirin or aspirin containing products for anyone under the age of 18.

Choose one of the following:

- This person takes **NO** medications on a routine basis. I give permission for the camp stocked over-the-counter medications to be administered on an as needed basis.
- This person takes their own prescription medication. I give permission for the use of camp stocked over-the-counter medications. To be administered on an as needed basis.
- Do not give my child any other over the counter medications.

GENERAL QUESTIONS: (Check only those that apply. Explain "Yes" answers below)

Has / does the participant:

- | | | | |
|---|--------------------------|--|--------------------------|
| Had any recent injury, illness or infectious disease within the last 6 months | <input type="checkbox"/> | Ever had problems with joints (e.g. knees, ankles, etc.).. | <input type="checkbox"/> |
| Have a chronic or recurring illness/ condition? | <input type="checkbox"/> | Have any skin problems (e.g. rash, itching? | <input type="checkbox"/> |
| Ever been hospitalized? | <input type="checkbox"/> | Have diabetes?..... | <input type="checkbox"/> |
| Ever had surgery? | <input type="checkbox"/> | Have asthma? | <input type="checkbox"/> |
| Ever had a head injury | <input type="checkbox"/> | Have mononucleosis in the past 12 months?..... | <input type="checkbox"/> |
| Wear glasses, contacts, or other eyewear? | <input type="checkbox"/> | Had problems with diarrhea / constipation?..... | <input type="checkbox"/> |
| Ever had frequent ear infections?..... | <input type="checkbox"/> | Have problems with sleepwalking? | <input type="checkbox"/> |
| Ever had seizures? | <input type="checkbox"/> | Have a history of bed-wetting?..... | <input type="checkbox"/> |
| Ever had high blood pressure? | <input type="checkbox"/> | Have any food drug allergies? | <input type="checkbox"/> |
| Ever been diagnosed with a heart murmur? | <input type="checkbox"/> | Ever had emotional difficulties for which professional help was sought?..... | <input type="checkbox"/> |
| Ever had back problems? | <input type="checkbox"/> | | |

Please explain any "yes" answers:

Date of most recent Tetanus Immunization Booster:

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health of which the camp should be aware (including learning disabilities).

IMPORTANT - The information below must be complete for attendance

Parent / Guardian Authorizations: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for my child.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. The completed form may be photocopied for trips out of camp.

I agree that The Master's Inn, its agents, officers, employees, trustees and volunteers will not be liable for any injury, death, damage and / or loss to this person, and / or anyone claiming on this individual's behalf, and I further agree to hold harmless, indemnify and defend The Master's Inn, its officers, staff, agents, employees, trustees and volunteers for and from any and all liability, claims, losses, injuries, expenses, fees and / or damages arising out of any injury, illness or death to this individual or property damage during their attendance at The Master's Inn.

Signature of Parent / Legal guardian or adult camper / Staff Member:
