Camp New Dawn
Medical Profile

To be completed and on file for everyone at camp. For campers and staff under 18, parent/legal guardian must sign.
Name:____
Last First Middle Prefer to be called
Age:______ Date of Birth:___________________

Street Address:_____________________________________ City:____________________________ State/Zip___________

PARENT/GUARDIAN INFORMATION:
1.____
Name Relationship Phone nos. (home, work, & cell)
2.____
Name Relationship Phone nos. (home, work, & cell)
____
Address (if different from camper)

IN CASE OF EMERGENCY, NOTIFY THE FOLLOWING IN ORDER LISTED AFTER ATTEMPTS TO ABOVE
1.____
Name Relationship Phone nos. (home, work, & cell)
2.____
Name Relationship Phone nos. (home, work, & cell)

Medical History

General health is: ____ Excellent ____ Good ____Fair ____Poor

Explain if fair or poor, citing restrictions in camp activities:
____

List any conditions or diseases for which you are currently receiving treatment and what treatment consists of:

____

List all conditions or diseases you received treatment for in the past, including surgeries and dates:

____

List all allergies:____

List any dietary restrictions:____

List any other special needs to include current *prescribed* medications. (Medications will be administered by camp nurse and must have the prescription label attached.)____
PLEASE PLACE MEDICATIONS IN A ZIPLOCK BAG, CLEARLY LABELED WITH YOUR CHILD'S NAME AND DATE OF BIRTH WRITTEN IN PERMANENT MARKER. MEDICATIONS MUST BE IN ORIGINAL CONTAINER WITH DOCTOR'S DIRECTIONS IF IT IS A PRESCRIPTION (NO PILLS IN BAGS.) DON'T SEND TYLENOL, IBUPROFEN, BENADRYL, PEPTO BISMOL, OR OTHER OVER THE COUNTER MEDICATIONS. WE WILL PROVIDE THESE, unless you instruct otherwise. PLEASE SEND INHALER IF YOUR CHILD HAS ASTHMA. PLEASE SEND EPI PEN IF YOUR CHILD HAS HISTORY OF SEVERE ALLERGIC REACTIONS. PRIMARY DISPENSING TIMES FOR MEDICATIONS WILL BE AT MEAL TIMES UNLESS OTHERWISE ORDERED.

Give names and contact numbers for any physicians that may need to be consulted, beginning with your family physician:
____ ____

Medical Insurance Company___________________ Policy ID #______________________ Phone No. ____________________________

I verify this informationt is true. The camper will engage in all camp activities except those noted. I further hereby agree to hold New Dawn International Ministries, Inc. and Camp New Dawn blameless in the event of injury or illness and release New Dawn International Ministries and affiliates from any and all actions, causes of actions, liability, claims and demands upon or by reason of damages, loss, injury or suffering which may occur. I give permission for treatment by a physician selected by the camp personnel to hospitalize, secure proper treatment for and to order injection anesthesia, or surgery for my best interest. I assume any and all responsibility for any expense incurred by prescribed treatment. I release Camp New Dawn from all liability in the administration of medications as I have listed above and on the intake/administration form.

____ ________________________
Signature Date

Attach a copy of your insurance card

Form M-1
CND